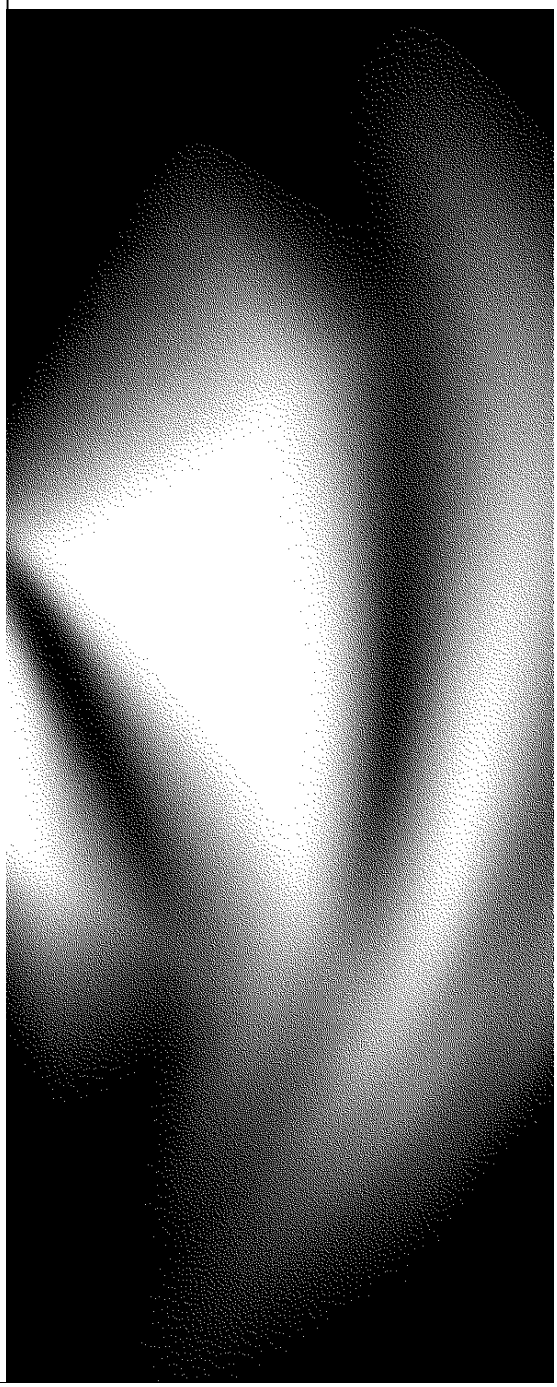
PRODUCTIVITY COMMISSION

Public Liability Claims Management

Research Report



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The Productivity Commission, an independent Commonwealth agency, is the Government's principal review and advisory body on microeconomic policy and regulation. It conducts public inquiries and research into a broad range of economic and social issues affecting the welfare of Australians.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

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Terms of reference

Benchmarking Australian Insurers' Claims Management Practices

PRODUCTIVITY COMMISSION ACT 1998

The Productivity Commission is requested to undertake a research study into Australian Insurers' claims management practices in the public liability class of insurance and benchmark them against world's best practice.

In undertaking this study, the Commission is to:

1. Benchmark Australian insurers' claims management practices against world standards, having regard to:
   (a) differences in legal processes between States and Territories in Australia;
   (b) the impact of litigation on claims costs;
   (c) the proportion of claims settled out of court and the factors determining which claims are settled out of court, and the size of these claims;
   (d) whether insurers collate claims history and what criteria for collation are used;
   (e) the time taken to finalise claims and factors determining this time;
   (f) the incidence of claims as a proportion of policies written and changes in the average size of claims over time;
   (g) the cost of claims management relative to the size of payouts, and the factors influencing this; and
   (h) any connection between claims management practices and the affordability, and the availability of public liability insurance.
2. Take account of recent substantive studies relevant to the study, including those by Trowbridge Consulting.
3. Consult with key interest groups, including insurance companies, as well as any other relevant parties.

The Commission is to report by 31 December 2002 and the report is to be published.

IAN CAMPBELL
26 July 2002

Foreword

In May 2002, a Ministerial Meeting on Public Liability agreed on a package of measures aimed at reducing claims costs and increasing the transparency of insurance industry practices through better data collection. As part of this package, Ministers agreed that the Productivity Commission be asked to benchmark Australian insurers' claims management practices against world standards.

This report is the Commission's response to that request. The Commission found limited scope for international benchmarking to be instructive in this area. However, the Commission's assessment of insurers' operations and their market environment is consistent with them having efficient claims management practices.

The Commission benefited from information and views received from the major insurers and other industry participants, including at a workshop held to discuss preliminary findings. The report also drew on a range of published sources, including studies by the ACCC and Trowbridge Consulting.

The study was overseen by Commissioner Judith Sloan and conducted within Inquiry B branch under Herb Plunkett. The Commission is grateful to all those who contributed to the report.

Gary Banks
Chairman

December 2002

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Abbreviations

ABI	Association of British Insurers
ACCC	Australian Competition and Consumer Commission
ACT	Australian Capital Territory
ADR	Alternative dispute resolution
APLA	Australian Plaintiff Lawyers Association
APRA	Australian Prudential Regulation Authority
CTP	Compulsory third party motor vehicle insurance
IAG	Insurance Australia Group
IBNR	Incurred but not reported
IBNER	Incurred but not enough reported
IC	Industry Commission
ICA	Insurance Council of Australia
ISA	Insurance Statistics Australia
ITR	Insurance trading result
LCA	Law Council of Australia
PC	Productivity Commission
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision

OVERVIEW

Key points

- The nature of public liability insurance has precluded the type of benchmarking the Commission has previously undertaken with economic infrastructure. The heterogeneous nature of the risks covered, as well as differences in institutional arrangements and regulatory regimes, limit the scope for policy-relevant, like-with-like comparisons between Australian insurers and with overseas insurers.
- The broad steps involved in managing claims are fairly common across the industry. Differences arise because, for example, the portfolios of public liability risks underwritten by insurers differ, and require different claims handling processes. It is widely recognised that there is no single best practice for public liability claims management.
- Insurers generally have sufficient information to manage their own claims effectively. But better use of claims data could be made by some insurers for a range of other purposes, such as premium setting and risk management.
- There is some state variation in claims management costs due to differences in statute law, legal representation costs and court procedures and costs.
- The involvement of lawyers in public liability claims has increased. Litigation, in the sense of the commencement of court-related processes, has also been increasing, although most cases are settled prior to trial.
- Setting premiums for public liability insurance is very difficult because of its 'long-tailed' nature (claims costs occur over many years) and the wide range of risks it covers. Since the mid 1990s, public liability insurance has operated at a loss.
- The market environment in which public liability claims are managed remains competitive and should provide sufficient incentives for insurers to make their claims management practices efficient and cost effective.
- There is nothing inherent in Australian insurers' claims management practices, or the environment in which they are undertaken, which would prevent the benefits from government initiatives to improve the availability and affordability of public liability insurance from being passed onto consumers.

Overview

Following public concern about the availability and affordability of public liability insurance, in early 2002 the Commonwealth, State and Territory Governments agreed on a package of measures to help alleviate the problem. These included: exploring options for tort law reform; pooling and group insurance for non-profit organisations; and the introduction by the Commonwealth of legislation to allow self assumption of risk for people who elect to participate in risky activities.

In response to concerns that the benefits of the measures may not be reflected in premiums, the Australian Competition and Consumer Commission (ACCC) was asked to extend its price monitoring of insurance premiums for a further two years and the Productivity Commission was asked to benchmark Australian public liability insurers' claims management practices against world standards.

Public liability insurance

Public liability insurance protects individuals, businesses and organisations against the financial risk of legal liability to third parties for death or injury, loss or damage to property, or 'pure economic' loss, in areas not covered by workers' compensation, motor vehicle compulsory third party (CTP), professional indemnity or product liability. The situations where such liability can arise are many and varied.

The available data on public liability insurance are incomplete and potentially misleading. Official data from the Australian Prudential Regulation Authority (APRA) are generally acknowledged to be inadequate to provide a meaningful picture of public liability insurance in Australia. The major insurers had difficulty in providing specific information for this study to the Commission, in part as a result of the HIH collapse and recent mergers and acquisitions.

While incomplete, insurance survey data obtained by the ACCC (2002b) included 13 selected insurers (including the six largest) which provided public liability insurance. Those insurers were estimated to provide 63 per cent of the written premiums of the public and product liability market as estimated by APRA. In 2001, they wrote some 1.5 million public and product liability policies and collected almost $600 million in premiums. Substantial amounts of public liability cover are

also written offshore, as is a large volume of reinsurance. In addition, significant self insurance is undertaken, typically by larger organisations with high 'deductibles'. In 2001, those 13 selected Australian insurers settled some 22 000 claims at an average settlement of around $15 000 per claimant. Trowbridge estimated that, while some three-quarters of the number of all claims were for property damage, bodily injury comprised 65 per cent of the total cost of settlements.

In setting premiums for public liability insurance, insurers rely on forecasts of future claims costs and investment earnings. This process is associated with considerable uncertainty, in large part because of the long time it takes — typically, three to five years — after the premiums have been received before reasonably accurate estimates can be made of the costs related to the cover provided. Hence, developments over time in elements of those costs can have dramatic effects on insurance profitability that are not immediately apparent.

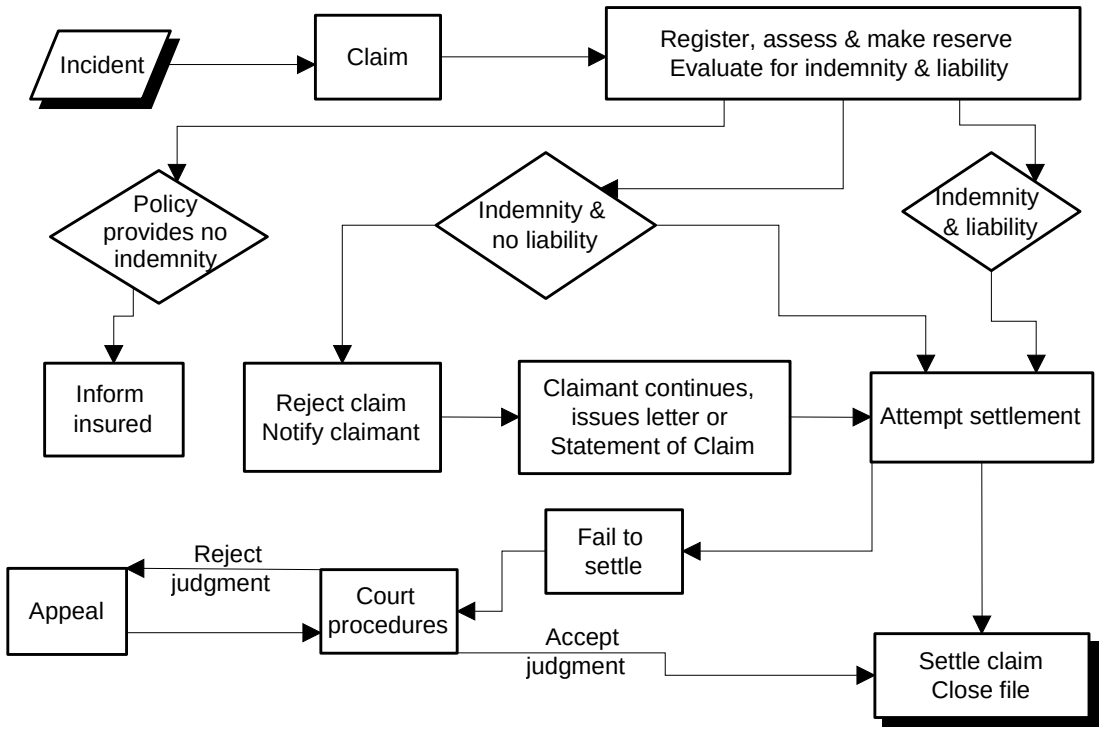
The insurance industry is known to be affected by cyclical behaviour. At present, public liability insurance is regarded as being in the 'hard market' stage of the cycle, when insurance cover is difficult to obtain and expensive. Accentuating this hard market have been the rapid escalation in the cost of personal injury settlements since the mid 1990s, greater legal involvement, the hardening of the reinsurance market following, in particular, the 11 September catastrophe and the collapse of HIH, a major domestic provider of public liability insurance.

What is claims management?

Claims management forms an integral part of public liability insurers' operations, together with marketing, underwriting and investing. It encompasses a range of activities from the receipt and registration of a claim, to investigation of the circumstances of the claim, to negotiation about indemnity and liability and the extent of the injured party's loss, through to settlement. A schematic outline of the processes involved is given in figure 1. As indicated, there are many possible pathways to resolving a claim.

The key objective of claims management is to provide policyholders with the contracted protection from the financial consequences of legal liability in an efficient and cost-effective manner. In practice, this entails containing costs by assessing the veracity of the claim and the insured's responsibility, and by settling claims expeditiously. To succeed, a claimant needs to demonstrate the existence of a duty of care, a breach of that duty and consequential material damage. This is undertaken within the legal framework set by the common law tort of negligence.

Figure 1 **Insurers' claims management process — a schematic outline**



The adversarial nature of the legal framework has a major influence on claims management practices, and heavily influences the costs and time taken to handle claims. Only some 2 to 5 per cent of claims are settled by the courts. Nonetheless, those decisions provide the parameters within which negotiations over claims take place and settlements are reached.

Over recent years, legal involvement in public liability has increased. Insurers report that about 80 per cent of the claims they handle are now accompanied by a solicitor's letter, compared with about half that level a decade ago. Greater use of lawyers may reflect a greater inclination by injured parties to claim, greater awareness of claimants' rights, or easier access to lawyers through 'no win, no fee' services. It may also reflect difficulties some people face in getting insurers to recognise their legitimate claims. Litigation — the commencement of court-related adjudication processes, irrespective of whether the case ends up in court — has also been increasing. However, these trends may be overstated as many small claims which do not involve legal representation are now managed by firms under self-insurance arrangements.

Typically, the cost of payouts to claimants (which include personal injury, property damage, economic loss, legal costs, investigation, etc) represents some 65 per cent of the net premium received by an insurer, or some 54 per cent of the purchase price

or premium paid by a customer (see table 1). Administration expenses, which include insurers' legal and other costs of managing claims, account for some 22 per cent of an insurer's premium.

Table 1 **Cost components of a public liability premium**
Per cent

Item	*Proportion of the net premium received by the insurer*	*Proportion of the premium paid by the customer*
Cost of claims	65	54
Commission/brokerage	15	12
Administration expenses	22	18
Investment income credit[a]	–10	–8
Target profit margin	8	7
Premium to insurer	**100**	**83**
GST[b]	10	8
Stamp duty[c]	11	9
Purchase price of premium to customer	**121**	**100**

[a] Allows for investment earnings on funds retained to pay claims. [b] Gross, as includes no allowance for refund of GST paid on purchased inputs. [c] Recently, some States and Territories have moved to reduce the amount of stamp duty charged on public liability premiums for some groups.

Source: Based on Trowbridge (2002a, p. 29).

The notion of benchmarking

Benchmarking is a process that helps firms identify 'best practice'. It involves firms making systematic comparisons of their procedures and outcomes with those of other domestic or international firms.

Benchmarking is most useful for public policy purposes when it involves comparisons of firms that operate in broadly similar circumstances and similar ways, and that produce like outputs. It is commonly used to compare the performance of public utilities and infrastructure — for example, electricity distributors, water supply authorities, ports and airports. However, benchmarking is more problematic in industries where heterogeneous goods or services are produced, mainly because it is difficult to make meaningful like-with-like comparisons.

In the case of public liability insurance, there is significant variation in the profile of the organisations and the public liability risks that they underwrite. Much more than other forms of insurance, the size, nature and complexity of claims vary enormously — from minor property damage to catastrophic bodily injury, perhaps involving

multiple defendants. On closer inspection, even superficially similar claims can involve sufficient differences in circumstances to make benchmarking uninformative. Thus, while at one level insurers tend to progress claims through a similar sequence of processes, the detail of each process varies between both claims and insurers. There are also differences between jurisdictions in court procedures and the costs of legal representation. Any comparisons with overseas insurers are further confounded by differences in institutional arrangements and legal regimes across and within countries (box 1).

Box 1 **International comparisons and claims management**

Among common law countries with similar legal and regulatory systems, there are important differences in statutory requirements and legal rules and procedures that affect the incentives faced by plaintiffs and insurers and influence approaches to claims management.

- There are statutory differences on such matters as caps on payouts, the size of legal fees in specified circumstances and the situations where strict liability must apply. These also vary within countries (for example, there are significant differences between American states and between Canadian provinces).
- Community concerns about liability insurance in the United States of America and Canada in the 1980s led to changes in legal and regulatory regimes for liability cases. However, some recent or proposed changes (such as class action reforms and caps on damages) are being reviewed and debate about the tort liability system continues.
- In most European countries, civil litigation generally follows the 'English rule', whereby the loser pays the winner's legal fees. In contrast, the 'American rule', which requires each side to pay its own legal fees, still applies to most civil litigation in that country. This influences the incentives to settle or to litigate.
- In contrast to Australia, Canada and the United Kingdom, jury trials are common in American liability cases. Its legal system also allows for the awarding of punitive damages.
- Attitudes towards litigation differ across countries, while advertising by lawyers and the availability of 'no win, no fee' legal services varies considerably between jurisdictions.
- Access to alternative dispute resolution procedures also varies. In the United Kingdom, for example, the Woolf reforms discourage litigation and encourage the use of alternative dispute resolution and sharing of information. However, if settlement is not achievable, there are requirements to ensure the parties are prepared to comply with court timetables and procedures.

These differences do not imply that some forms of benchmarking of claims management practices are not possible. At the level of day-to-day practices and

procedures, insurers can (and do) learn by comparing their activities to their own past performance, and to those of other local insurers, as well as to other areas of insurance, such as workers' compensation and CTP. They also adopt techniques and ideas from overseas insurers in countries with similar tort-based legal systems and regulatory arrangements.

However, in the light of the circumstances outlined above, it is doubtful if a single best-practice approach exists. Variations observed in practice between two insurers can simply represent efficient ways of managing the different 'parcels' of claims each handle. Claims managers told the Commission that, even between claims, the best practice process for one claim may not be best practice for another. In public liability claims management, flexibility is important and there is no 'world class benchmark' — a view widely supported by the full range of participants. The Commission agrees with this assessment. Hence, while potentially useful for insurers to undertake in relation to aspects of their own products, processes and practices, benchmarking has little meaning at the industry-wide level. Accordingly, it has little public policy significance.

For these reasons, the Commission concluded that it is not possible to undertake comprehensive and meaningful benchmarking of the type that has been undertaken in most of its other benchmarking studies (which have mainly related to economic infrastructure).

Nevertheless, in view of concerns about the efficiency of insurers' claims management operations, the Commission has reviewed the processes by which claims are managed to identify practices and objectives commonly pursued by Australian insurers and to canvass views about what might constitute best practice for different types of claims. It also examined the processes by which insurers review their own claims management processes. In addition, it considered the market environment in which Australian public liability insurers operate to help understand the incentives which the industry faces to manage claims in the most efficient and cost-effective fashion.

Is the market competitive?

In a competitive market, rivalry between firms, as well as the threat of new entrants, provides incentives for firms to operate efficiently in order to preserve or improve their market share and earn a commercial rate of return. Structural characteristics of the industry (for example, the number of suppliers), barriers to entry and exit, and market outcomes are commonly considered to provide an indication of the competitiveness of a market.

- Notwithstanding some recent mergers, there are still six large Australian-based general insurers that provide public liability insurance, plus a larger number of smaller firms. In many market segments, there is also competition from large overseas insurers and, increasingly, from (mainly large) firms that elect to self insure substantial layers of their risk.
- Recent developments indicate that barriers to entry and exit are relatively low. For example: there have been some mergers and acquisitions (such as the takeover of GIO by Suncorp-Metway); HIH exited in 2001; IAG has indicated that, conditional on further legislative reform, it may provide stand-alone public liability insurance; and QBE and others are now seeking to provide public liability insurance to not-for-profit agencies via a collective arrangement.
- Although there are some data shortcomings, both Trowbridge and the ACCC have reported negative returns for public liability insurance over recent years.

While some customers are having difficulties in obtaining insurance cover, this need not be inconsistent with a competitive market. Even though the industry is currently operating in a 'hard market', the scope for 'price gouging', a concern of some as premiums have risen, is minimal.

The Commission agrees with the judgment of the ACCC and APRA that the public liability market in Australia remains competitive, notwithstanding a reduction in the number of insurers offering this form of underwriting in recent years. There is competition between the major general insurers, new players may commence underwriting public liability risks at any time, and customers can (and do) insure overseas or self insure. There is also competition in the supply of claims management services, which can be provided by in-house claims management teams or by other insurance companies, or purchased from independent claims management companies or brokers.

Competition in the supply of public liability insurance provides incentives for insurers to make their claims management practices, and other facets of their business, efficient and cost effective.

Claims management practices

Even for claims that are ostensibly similar, their management needs to be tailored to deliver cost-effective outcomes in the light of the specific circumstances of each claim. The broad steps involved in claims management (see figure 1) are fairly similar across Australia, the United Kingdom and the United States of America. As noted above, differences between insurers in the execution of those steps, both

within Australia and overseas, relate to the detail of the procedures followed and the manner in which they are implemented.

In relation to the procedures:

- Although there are strong commercial incentives for insurers to settle claims expeditiously, there is significant variation in the time taken to resolve different types of claims. While property damage claims can usually be resolved relatively quickly (for example, within three to six months), personal injury claims can take much longer — often three to five years.
- While there was general agreement that claims management should be proactive, there are differing views as to what this entails. For insurers, being proactive relates to dealing with claimants in a timely manner and in progressing claims so as to avoid unnecessary delays in reaching a settlement. In contrast, for firms that self insure, a proactive approach focuses on minimising adversarial legal involvement by obtaining and acting on incident reports, and by using claims information for accident prevention.
- Some insurers have a detailed manual of procedures, some issue occasional guidelines and rely on in-house training and the experience of their staff, and others use key performance indicators to implement their claims management approach.
- The compilation and use of data from claims management are integral parts of insurers' financial reporting and management control systems. However, the extent to which claims data are available and used for other purposes varies across insurers.
  - Specialist claims managers pointed to the crucial role that claims data play in their operations, from internal control and reporting, to analysis and use of the data in providing information for their clients' internal risk management.
  - Some considered that insurers could do more to use their data to facilitate risk management by insured parties.
- There are differences of view as to whether, and in the degree to which, claims management operations are integrated into other parts of insurers' operations, such as marketing and underwriting. Some considered that formal separation of functions adds to the integrity of their individual and overall operations. But others felt that there were major benefits to be gained from developing a structured flow of information between them. They considered that this was one of the lessons Australian insurers could learn from the United States insurance companies.

In relation to implementation:

- The extent of geographic centralisation of claims management activity differs between insurers. Some consider that the economies of size and scope associated with centralising operations in one or two locations outweigh the benefits of having a more intimate knowledge of local conditions and legal systems. Other insurers hold the opposite view.
- Most, but not all, insurers employ specialised staff to handle public liability claims separately from other forms of liability insurance, where statutory provisions dictate many of the claims processing procedures. Some allocate claims according to difficulty and the expertise of staff, whereas others allocate claims as they come and, if needed, provide back-up support to less experienced staff.
- Some insurers make more extensive use of outsourcing than others. The degree to which insurers outsource claims management activities is driven by a number of factors, including:
  - corporate policy towards outsourcing of different functions, such as legal services, investigators and loss adjusters;
  - the stage which the claim assessment has reached;
  - the need for legal representation in particular jurisdictions; and
  - the expertise of existing claims management staff.
- The use of information technology to aid claims management differs among insurers. It is typically far less extensive than is used by specialist claims managers, where on-line reporting systems are routinely used with some accounts (for example, with higher frequency accounts covering 'slips and trips'). It appears that the sheer diversity and lower frequency of claims, and the relatively small size of the public liability claims management units, have meant that public liability claims areas have been one of the last areas of insurance to move from the tried and true paper-based systems.

Notwithstanding the differences in procedures and implementation, there was fairly universal agreement that good claims management seeks to: be proactive in recognising and paying legitimate claims; assess accurately the reserve associated with each claim; report regularly; minimise unnecessary costs; avoid protracted legal disputation; deal with claimants courteously and; wherever possible, handle claims expeditiously.

Review procedures

Insurers have a range of procedures in place to help ensure the efficient operation of their claims management activities. These vary from relatively simple administrative processes (for example, weekly checks of claims 'to do' lists and the preparation of monthly 'claims status' reports) to comprehensive reviews of a sample of claims and internal audits. These appear to be used by all insurers.

In many cases, staff assessments and bonuses are based on their performance in settling claims (for example, initiative taken in settlement, time taken and costs), reserving and following procedures. Most performance comparisons are against similar claims in previous years, although some insurers also set targets for particular types of claims (suitably adjusted for complexity).

Insurers' claims management operations are also subject to more extensive external reviews. For example, APRA requires insurers to implement risk management procedures in their claims management processes. And much more so than in the past, reinsurers now carefully review the claims management (and underwriting) practices of insurers whose risks they carry. Typically, they audit an insurer's internal processes and activities as part of the assessment of their own exposure. Such arrangements provide a valuable external check by firms with a clear commercial interest in ensuring that claims management activities are efficient and cost effective. They can also generate a two-way flow of information and ideas between the two groups, and help ensure that Australian practices remain internationally competitive. Typically examined are:

- delegations and authorities, including authority to settle claims;
- adherence to agreed company processes for claims handling (perhaps laid down in manuals or guidelines);
- progress in handling individual claims (for example, alerts for inactive claims and claims status reports);
- movements (and correctness) of amounts reserved as future liabilities;
- claims leakage (for example, payments for risks not covered by the policy, failing to make appropriate recoveries from reinsurers, spending on unnecessary investigations and excessive payments on claims); and
- performance assessment of claims managers.

Ideas, techniques and new information are also routinely disseminated via the international links which insurers have through ownership and reinsurance arrangements. Exchanges of staff, international conferences and the like further

encourage this. Insurers can also purchase the services of specialist insurance consultants.

In conclusion, the Commission considers that there is nothing inherent in insurers' claims management practices, or the environment in which they are undertaken, which would prevent the benefits of other measures taken, or planned, by governments to improve the availability and affordability of public liability insurance from being passed onto consumers.

Findings

Chapter 1: Introduction

FINDING 1.1

The Commission has not been able to carry out the traditional type of benchmarking analysis it has previously undertaken of economic infrastructure. The heterogeneous nature of the public liability insurance market and procedures for claims management limit the scope for making policy-relevant, like-with-like comparisons between Australian insurers. Differences in institutional arrangements and regulatory regimes create additional difficulties for international comparisons.

Chapter 2: Public liability insurance

FINDING 2.1

Setting premiums for public liability insurance is very difficult because of its 'long-tailed' nature (claims costs occur over many years) and the wide range of risks it covers. Since the mid 1990s, public liability insurance has operated at a loss.

FINDING 2.2

The industry is subject to cyclical behaviour and public liability insurance is now in the 'hard market' stage of the cycle. This has been exacerbated by the collapse of HIH and other shocks, including a series of insurance company mergers in Australia and overseas. Insurers are under pressure to review more critically the public liability risks they underwrite, the premiums they charge and how they manage claims.

FINDING 2.3

Public data on public liability insurance and claims are incomplete and potentially misleading. There is widespread acceptance of the need for better industry data, and processes have been set in train to achieve this.

Chapter 3: Market characteristics

FINDING 3.1

The public liability insurance market remains reasonably competitive, new players may commence underwriting public liability risks at any time, and customers can

insure overseas or self insure. There appears to be sufficient competition to provide normal commercial incentives for insurers to make their claims management practices efficient and cost effective.

Chapter 4: Claims management practices

FINDING 4.1

Fundamental to public liability claims management is the need to establish liability and the quantum of damages within an adversarial common law system. This has a major influence on the costs and time taken to handle public liability claims in Australia.

FINDING 4.2

Claims management practices are driven by commercial incentives for insurers to meet their contractual obligations to their customers in a cost-effective manner. The broad steps involved in managing claims are fairly common across the industry. Differences arise because, for example, the portfolios of public liability risks underwritten by insurers differ and require different claims handling processes.

FINDING 4.3

There is no single best practice for claims management — no 'one size fits all'. Management of claims for 'slips and trips', for example, can require significantly different approaches to claims for property damage or catastrophic bodily injury. Claims management needs to be tailored to deliver cost-effective outcomes in the light of the specific circumstances of each claim.

FINDING 4.4

The international links which insurers have through ownership and reinsurance arrangements, for example, encourage dissemination of ideas and techniques with respect to best practice in claims management. Exchanges of staff, international conferences and the like further encourage this.

FINDING 4.5

Insurers generally have sufficient information to manage their own claims effectively. But better use of claims data could be made by some insurers for a range of other purposes, such as premium setting and risk management.

Chapter 5: Legal costs and processes

FINDING 5.1

Legal costs are a necessary part of a well-functioning public liability system based on the need to prove or deny liability and determine damages under the common law tort of negligence. While efficiencies that lead to lower legal, and hence lower claims management costs, are desirable, unduly limiting spending on legal services is not necessarily appropriate and may lead to unsatisfactory outcomes.

FINDING 5.2

The involvement of lawyers in public liability claims has increased, with many insurers reporting that about 80 per cent of the claims they received are now being lodged by lawyers, compared with about half that level a decade ago.

FINDING 5.3

Litigation, in the sense of the commencement of court-related processes, has also been increasing, although most cases are settled prior to trial. The proportion of cases resulting in a judgment remains at about 2 to 5 per cent of cases.

FINDING 5.4

All jurisdictions have some form of court-based caseload management and alternative dispute resolution processes. There are cost incentives in place to encourage adherence to these new processes. While similar in broad intent and structure, there are differences in operation between jurisdictions. It is not clear the extent to which these have produced better outcomes in public liability cases.

FINDING 5.5

There is some variation between jurisdictions in claims management costs due to differences in statute law, legal representation costs, and court procedures and costs. If current state and territory reviews of arrangements for public liability insurance lead to greater differences, claims management costs to some insurers could rise further.

1 Introduction

Following a Ministerial meeting in May 2002, the Commonwealth, State and Territory Governments agreed, amongst other things, to ask the Productivity Commission to benchmark Australian public liability insurers' claims management practices against world standards. This introductory chapter provides a brief background to, and details of, that request. It also outlines the Commission's approach.

Recent problems in the public liability insurance market have resulted in some organisations and individuals facing either substantial increases in public liability insurance premiums or being unable to obtain cover.

Public concern about the availability and affordability of public liability insurance resulted in two meetings in early 2002 of Commonwealth, State and Territory Governments and the President of the Australian Local Government Association (the Ministers). In a joint communique from the second Ministerial meeting, the Productivity Commission was asked to benchmark Australian public liability insurers' claims management practices against world standards. The Ministers noted that some measures had already been initiated in the jurisdictions and agreed on a range of further measures to be undertaken — for example, an exploration of options for tort law reform and facilitating pooling and group insurance for non-profit organisations. The meeting also agreed to a range of other measures including the introduction by the Commonwealth of legislation to allow self assumption of risk for people who elect to participate in risky activities and the appointment of an expert panel to review the law of negligence.

1.1 Background

A range of factors have been cited as contributing to concerns about public liability insurance. However, there has been disagreement about whether some of the factors identified really have affected the price and availability of public liability insurance, and about the relative significance of some factors that are generally agreed to have contributed to the changed market conditions. Information and data outlined in subsequent chapters of this report shed light on some of those issues, although many are beyond the scope of this study.

Although in recent months some insurers have signalled their intention to offer public liability insurance, it is evident that there has been a reduction in the number of suppliers over the last few years. In this context, a significant factor was the collapse in March 2001 of HIH, the second largest insurer in Australia and a major provider of public liability insurance. Mergers and takeovers within the industry over recent years have also reduced the number of major insurers offering this class of insurance.

Insurers contend that increasing costs have contributed significantly to premium increases. Sources of cost increases are said to include:

- an increase in the number of claims (see chapter 2);
- an increase in the average value of claims, especially for personal injury (see chapter 2); and
- rising reinsurance costs — in part related to the 11 September 2001 terrorist attacks which led to the largest insurance payout in history. (Reinsurance allows a direct insurer to manage its own risk by 'offloading' part of the risk it has accepted to another insurer (called a 'reinsurer').)

Overlaying these developments, competition between domestic insurers during the mid to late 1990s meant that, while costs were increasing, real premium rates reduced steadily. As a result, many insurers experienced financial losses from this class of insurance. The average return to insurers for public and product liability insurance has been negative in recent years and the Australian Competition and Consumer Commission (ACCC) regards the outlook for rates of return for this class of insurance to be low (ACCC 2002b, p. vii).

The movement of most classes of insurance into the 'hard market' part of the insurance cycle in the past two years has also influenced availability and premiums (see section 2.1). (A hard market relates to higher premium rates and stricter conditions for underwriting risk, both in the direct market and the reinsurance market.) Traditionally, in this part of the cycle, insurers are cautious about growth opportunities, adopting a more conservative attitude to accepting risk and a greater focus on profitability. New capital adequacy requirements that were introduced from 1 July 2002 by the insurance regulator, the Australian Prudential Regulation Authority (APRA), and a decline in investment earnings as a result of a fall in the sharemarket, have placed further pressures on insurers.

The situation in Australia is not without precedent. For example, during the first half of the 1980s, the cost of all types of liability claims in the United States of America increased at rates exceeding 10 per cent per annum (Trowbridge 2002a, p. 74). As this was not recognised by insurers for several years, premiums remained

flat or in some instances declined. In 1985 and 1986, massive increases were made in claim reserves required to be put aside by insurers and in premium rates across the whole industry. Many insurers pulled out of the market and many customers could not obtain insurance at all, including some schools, hospitals, doctors, accountants, governments and corporations. Similarly, Canada experienced problems with liability insurance in the mid 1980s, leading to the establishment of mutual insurance pools for municipal authorities (Trowbridge 2002b, p. 54).

Adjustment to changes in public liability market conditions can be slower than for many other insurance markets. In large part, this is because liability insurance is so-called 'long tail' business where there is often a lengthy time period between both the injury and the claim, and the claim and settlement. It can take many years after a policy is written to determine the final result of claims originating in any year. Further, claims can be made many years after a policy has expired. This creates uncertainty for liability insurers who may pay a claim based on a premium charged years before.

These matters are discussed in this report to the extent that they impinge on claims management practices.

1.2 The reference

The Commission's study focuses on only one aspect of public liability, namely the claims management practices of Australian insurers. Specifically, it was asked to benchmark Australian insurers' claims management practices against world standards. In doing so, it was required to take account of a range of issues, including such matters as the cost of claims management relative to payouts, the cost of litigation, the impact of differences in state legal processes and the time taken to finalise claims. The Commission was also asked to take account of recent studies, including those by Trowbridge (2002a, 2002b), which was engaged to assist the Insurance Issues Working Group of Heads of Treasuries formed to support the Ministerial meetings held during the first half of 2002.

The terms of reference are at page III. The Commission was asked to report by 31 December 2002 and this report is to be published.

1.3 Related inquiries

The Commission's study is limited and should be seen in the context of a number of related actions and inquiries set in train to address public and government concerns.

- The Senate Economics References Committee conducted an inquiry into the impact of public liability and professional indemnity insurance cost increases on small business, community and sporting organisations. The inquiry was to have regard to the cost of such insurance, reasons for the increase in premiums and schemes, arrangements or reforms that can reduce the cost of such insurance and/or better calculate and pool risk. The Committee reported on 22 October 2002 (Senate 2002d).
- A panel chaired by the Hon. Justice David Ipp, Acting Judge of Appeal, Supreme Court of New South Wales reported in August (Ipp 2002a) and September (Ipp 2002b) following its examination of the law of negligence, including its interactions with the *Trade Practices Act 1974*. The review also considered the liability of public authorities, and joint and several liability.
- The ACCC reported to Government in March 2002 on recent changes in the insurance market and specifically on the upward movement of insurance premiums, including public liability insurance premiums (ACCC 2002a). Subsequently, the Commonwealth asked the ACCC to update this report, and to monitor general insurance premiums on a six-monthly basis over the next two years, to ensure that savings that result from reform measures are passed through to consumers in the form of lower premiums. The second ACCC report was released in September 2002 (ACCC 2002b).

1.4 The Commission's approach

Benchmarking claims management

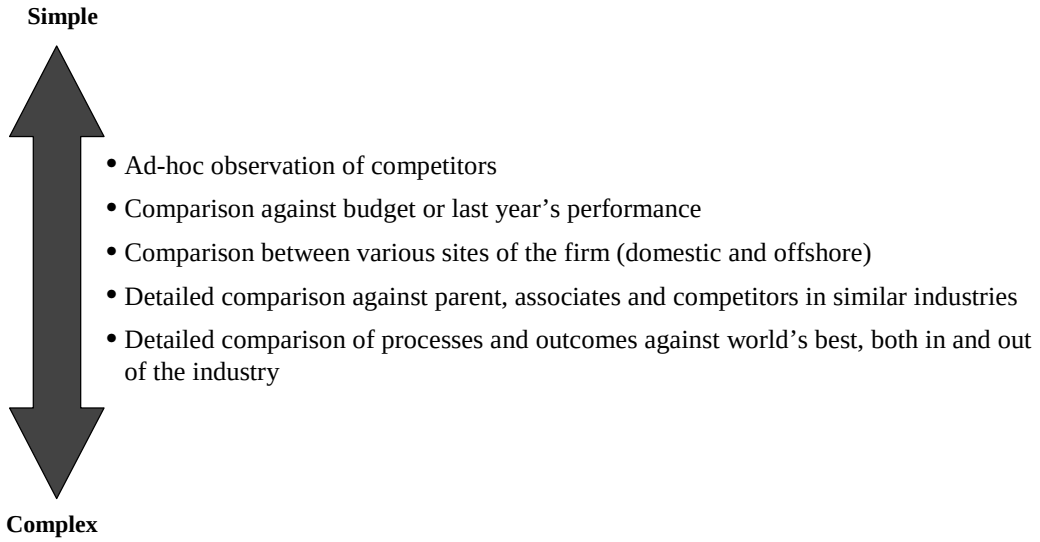
Claims management encompasses a range of operations from the receipt and registration of the claim, to the investigation of the circumstances of the claim and the setting of reserves, to negotiation about liability and the extent of the injured party's loss, through to settlement.

Benchmarking involves making systematic comparisons between firms, both domestically and with overseas firms, of procedures and outcomes. It aims to shift an organisation towards 'best practice' by drawing together information that illustrates how the firm compares with its peers, in order to pinpoint areas where improvement is possible. A variety of areas of business can be benchmarked, including business strategy, processes and products.

Firms undertake benchmarking as part of their search for better ways of operating in a competitive business environment. The nature of the benchmarking they

undertake can vary from simple ad hoc observations of other firms to complex comparisons of processes and outcomes with specifically chosen firms (figure 1.1).

Figure 1.1 **Levels of benchmarking**



Source: AMC (1994, p. 43).

For public policy purposes, benchmarking is commonly undertaken of public infrastructure and utilities, such as electricity distributors, water supply authorities, ports and airports. Typically, it involves detailed inter-firm comparisons of processes and/or costs between operators in different jurisdictions, domestic and overseas. Such comparisons work best when they involve firms that operate in broadly similar ways, using similar inputs to produce a similar range of outputs.

The use of benchmarking is, however, more problematic where heterogeneous goods or services are produced as it is difficult to make useful like-with-like comparisons. Public liability claims management falls into this category, as the types of claims incurred and the circumstances under which they are managed differ substantially between insurers (see chapters 2 and 4). Those differences directly affect the manner and cost of managing claims. In addition, the legal and regulatory environments applying in Australian jurisdictions differ somewhat from each other and, more significantly, from those applying in common law based jurisdictions overseas.

Consequently, there is little scope for industry-level benchmarking. Participants took the same view, telling the Commission that there is no 'world's best practice' against which the Australian industry could be benchmarked. According to local insurers, best practice for one claim may not be best practice for another — it depends on the individual circumstances of each claim and the environment in

which it is incurred. Indeed, differences observed in practice between two insurers could simply represent efficient ways of managing the different 'parcels' of claims each handles. Even within an insurer, there can be no best practice applicable to all claims. Different types of claims are best handled in different ways, and each insurer has to develop its own set of best practices (see chapter 4).

This does not mean that inter-firm comparisons of procedures and outcomes are not useful for insurers seeking to improve particular aspects of their internal processes and practices. Such comparisons may allow an insurer to take and adapt processes it observes elsewhere to its own benefit. But it does mean that detailed benchmarking of one insurer against another for matters of current public concern such as how long it takes to settle a claim, the average size of payouts or the proportion of cases that go to court, can have little normative significance for public policy purposes.

FINDING 1.1

The Commission has not been able to carry out the traditional type of benchmarking analysis it has previously undertaken of economic infrastructure. The heterogeneous nature of the public liability insurance market and procedures for claims management limit the scope for making policy-relevant, like-with-like comparisons between Australian insurers. Differences in institutional arrangements and regulatory regimes create additional difficulties for international comparisons.

Nevertheless, because of concerns about the cost and availability of public liability insurance, it is apparent that the community is seeking some assurance that public liability insurers are handling claims efficiently, particularly given that the industry stands to benefit from current and proposed legislative changes. The Commission has sought to address this underlying concern more directly. It has reviewed the processes by which claims are managed, to identify what many in claims management considered to be best practice for different types of claims, and has looked at the incentives which the industry has to manage claims in the most efficient and cost-effective manner.

Conduct of the study

On receipt of the terms of reference, the Commission advised interested parties by letter seeking their input into the matters raised in the reference. Wherever possible, material that was already available was used to aid in its analysis. As there is a lack of comprehensive and reliable data about the industry, the Commission has relied heavily on survey data obtained by Trowbridge, the work done by the ACCC and on submissions prepared for the various other studies and inquiries mentioned in section 1.3.

In attempting to understand what constituted best practice in claims management for Australian insurers, the Commission met with a range of individuals and organisations with knowledge of and experience with public liability claims management, including insurers, reinsurers, brokers, specialist claims managers, self insurers, plaintiff and defence lawyers, insured parties and professional organisations involved in the industry (see appendix A).

Through structured interviews with the six leading insurers in the Australian market, the Commission sought qualitative evidence and data on current claims management practices in public liability. While the discussions were helpful, attempts to gather quantitative data from the insurers were only moderately successful. The difficulties posed by the fallout from the HIH collapse, multiple computer systems within insurers and inconsistencies across time as a result of merger activity severely limited the collection of meaningful data.

Indeed, as noted in later chapters, much of the data provided to the Ministerial meetings and used in the broader public debate on public liability insurance is imprecise and at times impressionistic.

On 18 November 2002, the Commission held a roundtable in Sydney to obtain feedback on a draft working paper outlining some preliminary findings.

The Commission records its thanks to all those who contributed to this research project and provided feedback on the Commission's work.

1.5 Structure of the report

The remainder of the report is structured as follows:

- Chapter 2 outlines what public liability insurance is and how it is provided, gives some indication of recent public liability insurance activity and summarises Commonwealth and State responsibilities and powers in this area.
- Chapter 3 deals with the public liability industry structure and market, and examines the competitiveness of the industry.
- Claims management practices, and views of best practice in this area, are discussed in chapter 4.
- Chapter 5 explores the importance of legal costs in managing claims, provides some indication of the impact of litigation and court processes on claims costs and outlines some differences between jurisdictions.

2 Public liability insurance

Public liability insurance protects individuals, businesses and organisations against the financial risk of legal liability to third parties for death or injury, loss or damage to property, or 'pure economic' loss in areas not specifically excluded or covered by statutory schemes (workers' compensation and motor vehicle compulsory third party (CTP)), professional indemnity and product liability.

Within the public liability insurance industry there are a number of players, including insurers, claims management firms, reinsurers and brokers. Each is involved in claims management to a greater or lesser extent. The amount of self insurance in the market is increasing, as insurers reconsider the risks they underwrite, the premiums they charge and the level of deductibles they require.

Although the data have some limitations, it appears that the frequency of public liability claims has been steady, but that the average size of claim has increased, particularly for bodily injury claims.

Liability for personal injury or property damage can arise in many contexts, including in the workplace, in respect of a matter covered by a contract, or as a result of a motor vehicle or other accident. Various types of liability insurance are available to reduce the exposure of organisations and individuals to such risks.

Public liability insurance is commonly taken out by owners and operators of a wide range of commercial and non-commercial activities, including homes and businesses, shopping malls, swimming pools, surf lifesaving clubs and local carnivals. In some cases, public liability insurance is required by law before a business can operate or a service be provided (ACCC 2002b, p. 44).

Public liability insurance protects individuals, businesses or organisations against the financial risk of being found liable to a third party for death or injury, loss or damage of property, or 'pure economic' loss resulting from negligence by the

insured. However, public liability insurance policies exclude many areas of potential liability,[1] such as those covered by:

- *motor vehicle insurance* (third party cover is compulsory under state and territory legislation);
- *workers' compensation insurance* (compulsory under state/territory legislation);
- *medical and other professional indemnity insurance* (for professional services offered by the insured); and
- *product liability insurance* (for losses attributable to products manufactured or sold by the insured).

These four areas account for most of the personal injury litigation in Australia:

> Nearly all personal injury litigation arises out of motor vehicle collisions, industrial accidents, product defects and professional malpractice, where the usual cause of action is negligence, and the damages are paid by an insurer or corporate employer. (Luntz 2002, p. 4)

Compulsory third party and workers' compensation schemes are often termed 'statutory' schemes because insurance is compulsory under legislation, and such matters as benefit entitlements and how claims are handled are defined by statute.

Benefits under those two schemes comprise a mix of common law entitlements and statutory benefits. In contrast, public liability claims are handled primarily under common law processes, with the background of court judgments as to heads of damages and payout amounts.

This chapter looks at what is covered by public liability insurance arrangements, provides some indication of recent public liability insurance activity and summarises the regulatory roles of the Commonwealth, State and Territory Governments. As such, it provides background information for subsequent chapters.

2.1 What is public liability insurance?

Insurance as a pooling of individual risks

As with other kinds of insurance, the principle underpinning the offer and pricing of public liability insurance is that of transferring the potential costs of individual risks

[1] Public liability policies are typically open-ended, in that they cover all liability in respect of a particular activity or location, other than circumstances specifically excluded by the policy. Policies are generally limited by exclusions, rather than by listing what is included.

for a certain fee, and the pooling of premiums to meet individual events as they occur:

> Insurance is the gathering of a pool by way of premiums to meet claims/liabilities that might arise. People and organisations that wish to protect their property and liability subscribe to the fund. The premium pool must have sufficient funds to meet claims that arise along with the insurers' operational expenses and profit requirements. Depending on the number of claims and their quantum amount, premiums are set. (ICA 2002b, p. 1)

A key element is that the policyholder (the insured) is able to transfer to others much of the financial risk which is necessarily present in all activities that it would otherwise face alone:

> Without insurance, the risk of an adverse event may not be affordable to individuals or groups, and so some economic and social activities may not take place. (Treasury 2002, p. 1)

In the case of public liability, the risk arises from the application of the common law tort[2] of negligence, under which legal liability can arise if a member of the public suffers personal injury or property damage that is attributed to the insured. Risks may vary from a largely predictable number of, for example, 'frequency' events (such as 'slip and trip' accidents in a supermarket) to the highly unpredictable, such as claims arising from a major accident.

As noted in chapter 1, the insurer may subsequently transfer some of the financial risk it carries via reinsurance.

Determining liability

While 'strict liability' can be specified under contracts, or is required by laws such as those covering occupational health and safety or consumer protection, a public liability claim usually seeks financial compensation by arguing that the injury or loss sustained arose because of a breach of the 'duty of care' owed to the third party by the insured.

To succeed, an injured party needs to demonstrate:

- the existence of a duty of care;
- a breach of that duty; and
- material damage as a consequence of the breach of duty.

[2] A tort is any wrong other than a criminal wrong, as in negligence, defamation, etc.

The existence and scope of duty of care is a matter determined by the courts applying common law principles. The Law Council of Australia said that:

> … broadly, negligence requires someone who has a duty of care to take reasonable care to protect against forseeable harm. What is reasonable is decided on balancing the likelihood and severity of an injury that may occur on the one hand, and the cost and inconvenience of obviating that risk on the other hand. (2002a, pp. 25–6)

Some states have recently passed legislation dealing with some aspects of public liability claims, including payouts and processes. But this aside, there is little legislative guidance as to how liability is to be judged and compensation determined:

> Claims are dealt with under 'common law' principles established through a long history of case law and, if litigated, are made by way of civil actions in the relevant jurisdiction. (Trowbridge 2002a, p. 3)

Consequently, the extent of damages and the matters considered in arriving at that estimate are also matters for the courts. The general principle upon which the courts operate is that:

> … the damages to be recovered are in money terms no more and no less than the plaintiff's actual loss. (Luntz 2002, p. 4)

However, while the principle is widely accepted, there can be considerable difficulty in practice in deciding the quantum of damages (see Luntz 2002). For example, following the 1997 High Court decision in Griffiths v Kerkemeyer, the heads of damages for public liability were expanded to include payments for personal care by relatives. Over time, payouts have also been affected by such developments as the introduction of compulsory superannuation in 1993, increased life expectancies leading to higher awards for future care and the greater number of persons involved in high risk activities (Cumpston Sarjeant 2002, p. 6).

Liability does not have to be proven in court and, in practice, few public liability claims are resolved this way (chapter 5). Most are settled by negotiation and agreement, with or without the involvement of legal representatives, without resort to court determination (Trowbridge 2002a, p. 2). Nevertheless, court decisions provide the parameters within which negotiations take place and settlements are reached.

Pricing public liability risk: the 'long tail'

Public liability insurance is often referred to as 'long-tail' insurance, as many years may pass between the period for which cover was provided and the date at which

claims arising from incidents during that period are finally settled.[3] The delay may occur because, for example, injured people may wait until their injury stabilises before making a claim. Upon receipt of a claim, the insurance firm must then investigate the claim, negotiate with the client and perhaps seek an outcome through the legal system.

Depending on statutes of limitations, which vary by jurisdiction, claims can be made for some years after an accident, even if the policy has expired. For example, the Insurance Council of Australia said:

> If a child of one year of age in NSW was injured, legal action could be commenced some 25 years after a policy has expired. There is no need to commence legal action until 18 years of age and the Statute of Limitations of 3 years applies. A further extension of 5 years may also be granted. (ICA 2002b, p. 4)

Trowbridge noted that:

> It takes three to five years before a reasonably accurate estimate can be made of the cost of claims from a given year of insurance. (2002a, p. 3)

In contrast, most claims for damage to motor vehicles or homes tend to be made in the year for which cover is provided. This simplifies the estimation of the loss parameters.

Public liability risks may also be 'fat tailed':

> … in the sense that the probability of very high pay-out events is large relative to the probability of such events in the case of other insured risks. (ACCC 2002b, p. xii)

Thus, while the likely number, size and nature of claims are central to the setting of public liability premiums, insurers find it difficult to predict how big future public liability claims might be. And, over time, injuries, claims information and the legal environment can change. As the Insurance Australia Group observed:

> … a policy written today is not priced on the basis of the current cost of claims but on an estimate of claims costs when claims under that policy will, on average, be paid out. … Premiums are therefore based on the expected growth of average claims costs over the average duration of the claim, and then discounted for the expected investment earnings on claim reserves over that period. Under-pricing (and potentially over-pricing) occurs when these estimates prove to be seriously inaccurate. (2002, pp. 1–2)

Consequently, setting the 'right' premium is difficult at the best of times. The Institute of Actuaries said:

[3] Other forms of long-tail insurance include medical indemnity insurance, workers' compensation and CTP.

> There is a long history of substantial losses by insurers writing various forms of liability insurance. In some cases, this is an issue of incompetent (or even no) underwriting, but mostly it reflects the extreme difficulty of assessing the probable cost of Public Liability risks. Despite a long history of such things, insurers continue to be surprised by the new and inventive ways in which people can injure themselves and others, and to be caught by the extent to which acceptable standards change over time. (2002, p. 11)

FINDING 2.1

Setting premiums for public liability insurance is very difficult because of its 'long-tailed' nature (claims costs occur over many years) and the wide range of risks it covers. Since the mid 1990s, public liability insurance has operated at a loss.

The ACCC has recently assessed the outlook for return on capital for public liability insurance to be low (see section 2.4).

The insurance cycle

Insurance is an industry known to be affected by cyclical behaviour. Conditions in the insurance market typically cycle between 'hard' and 'soft', as providers seek to maintain both market position and profitability. In a 'hard market', insurers focus more closely on profit and may decline to insure some activities or industries. As profits and opportunities improve, new insurers enter the market, and premium prices fall in the ensuing more competitive environment. At some point, the market turns 'soft' — insurers incur losses and some may even fail. After a time, premiums begin to rise and insurers withdraw from underwriting particular risks. That is, conditions will again move towards a 'hard market' (figure 2.1).[4]

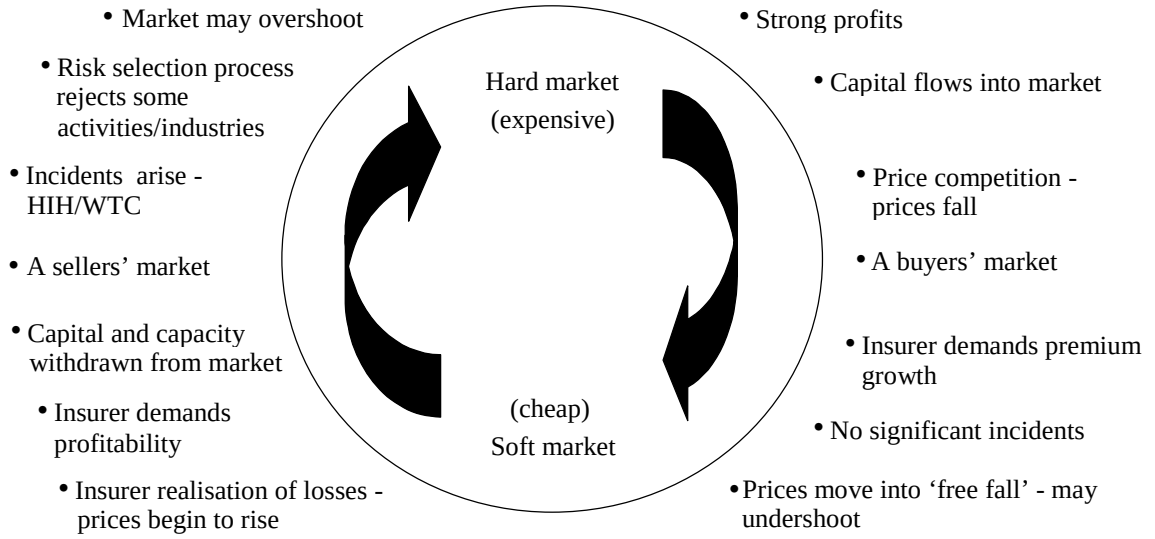
The public liability market was considered to be in the 'soft market' stage of the insurance cycle in the mid 1990s and to be hardening in the late 1990s. This coincided with a tightening in the reinsurance market, which hardened further following the destruction of the World Trade Centre. The collapse of HIH has also been a major influence, as it dominated the Australian market in areas presently experiencing the most difficulty in obtaining cover and where the largest increases in premiums have since occurred.

As insurers must set premium prices before they incur the bulk of the associated costs, the potential for under-pricing, subsequently incurring losses and setting off

4 A number of hypotheses have been advanced for this behaviour. All reflect the lag between the provision of cover and the finalisation of claims relating to incidents which occurred during that period.

or accentuating a cycle is high, especially in 'long-tail' insurance such as public liability.

Figure 2.1 **The insurance cycle**
From profits to losses



Source: Reproduced from Trowbridge (2002a, p. 9).

A direct result of the insurance cycle is that different degrees of competition and market power will be displayed over time, as firms experience varying levels of growth and decline. Consequently, looking at the market at any one point in time and assessing the level of competitiveness without taking into account the ongoing dynamics, may provide a misleading picture (chapter 3).

FINDING 2.2

The industry is subject to cyclical behaviour and public liability insurance is now in the 'hard market' stage of the cycle. This has been exacerbated by the collapse of HIH and other shocks, including a series of insurance company mergers in Australia and overseas. Insurers are under pressure to review more critically the public liability risks they underwrite, the premiums they charge and how they manage claims.

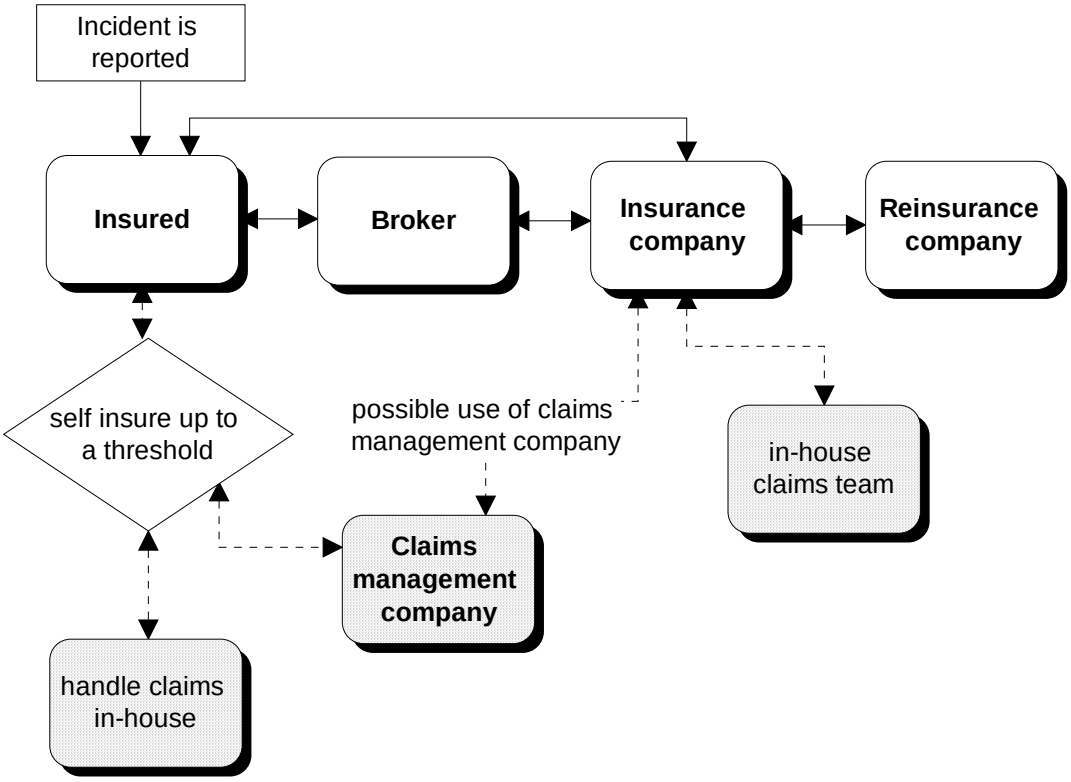
2.2 How is public liability insurance provided?

On the basis of its governing legislation, the insurance market in Australia may be divided into life, health and general insurance. Public liability insurance is provided in the general insurance market, which covers liability and similar products, such as workers' compensation, CTP, professional indemnity and product liability. General

insurance also encompasses products that cover loss or physical damage to property, such as home and motor vehicle insurance. Jenkins (1998) noted that the long-tail products (liability) accounted for around 25 per cent of total general insurance premium income in the private sector in 1998, while the short-tail products (property) represented around 75 per cent.

The public liability insurance market itself has a number of elements. While the underlying demand in this market is for the transfer of financial risk of public liability claims, there is also demand for the management of those claims. For insurers, underwriting and claims management are core operations, along with marketing and investment. Insurance firms can therefore supply both financial risk transfer and claims management in one package. Claims management may also be undertaken by specialist claims management firms, brokers or the insured parties themselves. Figure 2.2 illustrates some of these key relationships.

Figure 2.2 **Claims management: the key players**



Following a period of corporate restructuring (box 2.1), the general insurance market in Australia is now dominated by a number of big players. During 2001, IAG, Royal & SunAlliance, CGU, Suncorp-Metway, Allianz and QBE each took in more than $1 billion in premium revenue and together accounted for more than half of the market (APRA 2002c, table 14b). The remainder of the market was made up

of about 150 insurers. The composition of the public liability market is explored in more detail in the next chapter.

Box 2.1 **Changes in the general insurance market**

HIH has been the catalyst for several changes in the market in recent years. After a succession of acquisitions, including FAI in January 1999, HIH encountered difficulties. Its 'small commercial' insurance business was sold to Allianz in August 2000 and its 'large commercial' to Gerling in November 2000. QBE later acquired the renewal rights for HIH's large commercial portfolio, while NRMA acquired its workers' compensation business. The HIH collapse in March 2001 is presently subject to a Royal Commission (www.hihroyalcom.gov.au).

The ACCC expected that the repercussions from the HIH collapse will continue into the next decade, as claims continue to arise and become subject to dispute, and as other insurers are left to fund their defence and possibly bear the full cost of the losses. In addition:

> The critical impact of the liquidation of HIH was that it highlighted classes of insured that had been underwritten by HIH, which the market considered were at unprofitable levels. Placement of these risks with other underwriters represented significant and, in many instances, unaffordable increases in the cost of insurance. (2002b, pp. 122–3)

Other major influences on the market included:

- the merger of General Accident (NZI in Australia) with Commercial Union in 1997, to create CGU;
- the purchase of MMI by Allianz in late 1998;
- the merger of Sun Alliance and Royal Insurance in 1992 to create Royal & SunAlliance;
- the sale of Fortis to CGU in June 2001; and
- the announcement in 2002 that IAG was seeking to purchase CGU.

Sources: Trowbridge (2002a, p. 10) and ACCC (2002a, pp. 9–10).

The major general insurers underwrite public liability insurance either as a stand-alone product or in conjunction with car, house, business or other forms of insurance. Public liability insurance is also provided by certain mutual insurers.[5]

For the general insurance sector as a whole, public liability accounts for only a small part of total underwriting. In 2001, public and product liability (commonly

[5] These mutual companies are not subject to the Insurance Act and their activities are not included in APRA statistics.

sold as a package for many businesses[6]) together accounted for about 5 per cent of premium revenue and 6 per cent of policies written (ACCC 2002b, p. 23).

Public liability insurance is often obtained through brokers, who seek out and negotiate underwriting arrangements for their customers. Brokers may place public liability business within Australia or in an offshore market (for example, in the London insurance market, where several underwriters specialise in Australian insurance business). Participants estimated that between 10 and 40 per cent of public liability insurance is placed with offshore insurers.

International links

Most of the major general insurers in Australia operate nationally and some have strong international links via their ownership arrangements. For example, Royal & SunAlliance is part of the global Royal & SunAlliance Group and CGU is part of the CGNU plc Group, formed in 2000 through the global merger of CGU and Norwich Union. These links facilitate inter-company transfers of ideas and people, cross-company comparisons of underwriting, investment and claims management practices and so on.

The global nature of reinsurance also links Australian insurers to developments in the international insurance market. About 29 reinsurers operate in Australia. Most are branches or subsidiaries of overseas firms. Some reinsurance from Australia is placed directly into overseas markets, particularly with Lloyds and the London Market. In 2001, about 22 per cent of premium revenue for public and product liability insurance written in Australia was ceded as reinsurance (compared with an average of about 28 per cent for all classes of business) (ACCC 2002b, pp. 109–10).

As noted earlier, the cost of reinsurance has risen. APRA said that:

> … it is increasingly difficult post 11 September for direct insurers to obtain affordable reinsurance in the contracting international market. Reinsurance rates available to local insurers have recently risen on average by around 25%. Even before September 11, APRA statistics showed reinsurance expenses increased by 59% over the three year period to June 2001. While capital inflow into international reinsurance will over time moderate the rising costs, this will likely take years rather than months. (2002k, p. 2)

The ACCC estimated that reinsurance costs accounted for about 5 percentage points of the 22 per cent average premium increase for public and product liability in

[6] Trowbridge (2002a, p. 2) noted that 'In most industries, and especially for smaller businesses, public liability and products liability have been sold as a combined product with a single premium amount. Usually, therefore, statistics are only available for public and products liability combined'.

2001-02 (2002b, pp. 38, 42). It noted that competition among reinsurers in the late 1990s resulted in some under-priced reinsurance, consequent losses, a reduction in the level of capital in the market and an increase in reinsurance rates. Even before the terrorist attacks of 2001, there were indications that reinsurers were increasing their rates. In turn, those events led to further increases.

The ACCC referred to the parallel consequences for the insurance industry of Hurricane Andrew in 1992 and the terrorist attacks of September 2001, noting that both 'destroyed a considerable volume of capital' and precipitated a 'hardening' in reinsurance rates (2002b, pp. 114–15).

Insurers have responded by more critically reassessing the risks they will underwrite and the returns on the capital they employ:

> Shareholders of insurers effectively compel this reassessment … as the events demonstrate … the high risks associated with insurance. … To restore investor confidence insurers needed to rebuild their balance sheets and increase returns to shareholders … This is achieved through more disciplined underwriting. [It also] takes the form of higher premiums, increased policy deductibles, limits on policy covers, exclusions in cover, etc. (ACCC 2002b, pp. 115–16)[7]

2.3 Self insuring for public liability claims

The risk of liability for claims is generally shared between the insured and the insurer, with the insured bearing the financial risk of claims for amounts smaller than a threshold level (the 'deductibles' level). By retaining a higher level of the financial risks through a higher level of deductibles, the insured can obtain a lower premium.

Insurers may require deductibles for clients likely to generate relatively high frequency small claims, such as result from 'slips and trips' in shopping centres. In some cases, a high level of deductibles may be a condition for obtaining insurance.

The size of deductibles required by insurers may have varied in recent years in response to changes in the public liability market. But there is very little hard data on this matter. The Institute of Actuaries said that:

> Deductibles … are generally a few hundred dollars for small policies, but can be very large for large corporate clients. In effect, some corporations act as self-insurers [for most claims], with the insurer only picking up the highest layers of the very largest claims. (2002, p. 6)

[7] Other responses include excluding acts of terrorism from policies (this took effect for many December 2001 renewals) and, in some cases where losses of capital have proven too great, exit from the market.

Finnis, in a paper prepared for the Insurance Council of Australia said that:

> One leading insurer … mentioned to me that the minimum deductible for corporate entities has increased fivefold in recent times. Overall, a 50% increase in the average deductible amount has been observed over the last 2 years or so. (Finnis 2002, p. 4)

One major insurer, for example, said that, whereas about 10 per cent of policies in 2001 had deductibles over $5000, the comparable figure for 2002 was 23 per cent. Moreover, the number of policies with a deductible of $20 000 or more had risen from 3.1 per cent to 8.4 per cent in the past year — and is still on the rise.

Royal & SunAlliance, referring to its experience over the past 15 years, said that:

> … certainly, for larger corporate organisations, that excess will have changed over a period of time, but for smaller retail type organisations that excess has not changed … if anything, the excess is reduced in what we would call the soft market. So, when prices go down, not only do prices go down but the excesses go down … For periods when the concern comes through, which are the 1997-2000 accident years, at that stage in the cycle of the market, there would have been lower excesses rather than higher excesses. (Senate 2002c, p. E352)

Management of 'under deductible' claims may be undertaken by the insured itself (some major retailers take this approach), by specialist claims management companies, or by the insurer acting as an agent for the insured (chapter 4). One insurer said that where five or more 'under deductible' claims are expected on a policy, it requires the appointment of a third party claims management company and determines the arrangements for the handling and reporting of those claims. However, insurers vary in the extent to which they require details of claims falling below the threshold to be reported to them.

One implication of this form of self insurance is that many claims are absent from insurer-based statistics on public liability. Claims statistics are discussed later in the chapter.

Incentives to manage risk

Having to manage a proportion of their own claims sheets home to policyholders the cost of accidents, even more directly than do premium increases. Citing American experience, Proclaim said that:

> Companies have found this increases their risk management focus and gives them greater control over their risk and premiums. (2002, p. 1)

More generally, common law liability for negligence has implications for incentives to invest in safety and otherwise undertake risk minimisation. The possibility of being subject to a successful public liability claim provides a disincentive to

behaving negligently and a positive financial incentive to spend on safety measures to minimise risks to the public (Ergas 2002, p. 4). As the ACCC noted in its submission to the Ipp inquiry:

> The aim is to prevent … accidents occurring in the first place by providing incentives for each person, to invest, according to the specific costs and benefits he or she faces, in precautions up to the point where the marginal benefits from such investment in reducing the incidence and costs of possible accidents equal the marginal costs. … Negligence law and product liability law are both different ways of achieving this aim in different contexts. (2002c, pp. 10–11)

While the primary role of public liability insurance is to protect those who would otherwise have to pay common law awards, it also provides financial protection for injured persons, to the extent that any party found liable for damages would not otherwise be able to afford the compensation awarded. Indeed, some have argued that the application of tort law is itself substantially influenced by the existence of insurance (for example, joint liability and the so-called 'deep pocket syndrome'). The Institute of Actuaries said:

> The changes in Tort law have been partly driven by the existence of liability insurance. At the same time, the changes in Tort law have made liability insurance much more necessary. This symbiotic relationship between Tort law and Public Liability Insurance means that the two systems must be reviewed together. (2002, p. 1)

2.4 Public liability insurance activity

Obtaining a clear picture about public liability insurance, and claims in particular, is difficult. The quality of industry data is poor, hampering a fuller understanding of what has been happening in recent years. This has been a consistent message from recent reviews, including reports prepared for the recent Ministerial forums on public liability (Trowbridge 2002a, 2002b).

Nevertheless, it is clear that the cost and availability of cover has become a problem for some businesses and organisations, some of which have been unable to secure insurance at premiums similar to those they had been paying in the past or, in some cases, at any price. Royal & SunAlliance said that:

> … for the first time — certainly in a generation, if not in living memory — people have not been able to get insurance cover for certain events. That is something that never existed previously. If they can get the cover, they can only get it at significantly increased prices. (Senate 2002c, p. E354)

As noted earlier, there is some evidence that insurers are being more rigorous about the types of risks they will carry, in part as a response to continuing losses in public liability insurance, the 'hard market' stage of the insurance cycle, rising reinsurance

costs and repercussions of the HIH failure. Moreover, APRA and insurance company data show that this activity has generated losses for some years (and in view of occasional assertions of under-reserving for future claim liabilities, actual losses in some years may have been higher than reported) (Treasury 2002, p. 5; Trowbridge 2002a, p. 32).[8]

Premium rate increases

The premiums that insurers charge comprise a number of components. For general insurers, Trowbridge estimated that the cost of claims represented about 65 per cent of the total of a typical public liability premium (table 2.1). Sampling of claims indicated that about 49 per cent of the total comprises compensation to claimants and plaintiff legal costs, 13 per cent is for insurer legal costs and 3 per cent for investigation costs.

Table 2.1 **Cost components of a public liability premium**
Per cent

Item	*Proportion of the net premium received by the insurer*	*Proportion of the premium paid by the customer*
Cost of claims	65	54
Commission/brokerage	15	12
Administration expenses	22	18
Investment income credit[a]	–10	–8
Target profit margin	8	7
Premium to insurer	**100**	**83**
GST[b]	10	8
Stamp duty[c]	11	9
Purchase price of premium to customer	**121**	**100**

[a] Allows for investment earnings on funds retained to pay claims. [b] Gross, as includes no allowance for refund of GST paid on purchased inputs. [c] Recently, some States and Territories have moved to reduce the amount of stamp duty charged on public liability premiums for some groups.

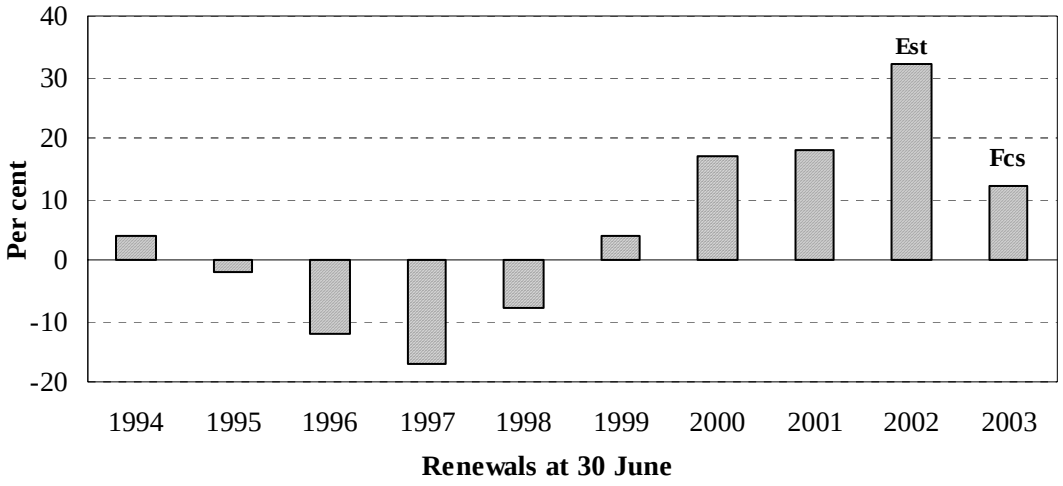
Source: Based on Trowbridge (2002a, p. 29).

On average, premiums for public liability insurance fell in 1996, 1997 and 1998. There was an overall decline of about 35 per cent between 1993 and 1998. However, this trend has since reversed, with large increases in 2000 and 2001 (figure 2.3). Trowbridge expects average premiums to rise by about 30 per cent

[8] A presentation to an insurance industry seminar in 1999 argued that 'public liability [insurance] may be under-reserved by $500m to $1000m at December 1998 or 25% to 50% of outstanding claims reserves at that date' (McCarthy and Trahair 1999, p. 4).

during 2002 and by a further 11 or 12 per cent by 30 June 2003 (Treasury evidence to Senate 2002b, pp. E332, 336).

Figure 2.3 **Annual changes in premium rates since 1994**



Est: estimate; *Fcs:* forecast.

Source: Trowbridge (2002a, p. 26), drawing on the 2002 Interim Insurance Survey by JP Morgan and Deloitte/Trowbridge (Deloitte 2002), which reports premium rate changes advised each year by insurers and brokers.

In Trowbridge's assessment, hindsight has revealed that insurers under-priced public liability insurance during most of the 1990s, and are now determined not to repeat this. They will now not underwrite risks that do not meet strict underwriting criteria. Trowbridge considered that recent changes in attitude have been heavily influenced by the failure of HIH, which was acting as a 'cut price' insurer (2002a, p. ii). The 2002 Interim Insurance Survey by JP Morgan and Deloitte/Trowbridge also concluded that:

> … the industry's resolve to improve its risk/reward position has been the greatest driver of the increase in premium rates. (Deloitte 2002, p. 1)

However, the Institute of Actuaries cautioned that, notwithstanding the difficulties caused by poor data:

> … it is clear that premiums have been grossly inadequate in the recent past and we doubt whether recent premium increases will prove adequate. (2002, p. 12)

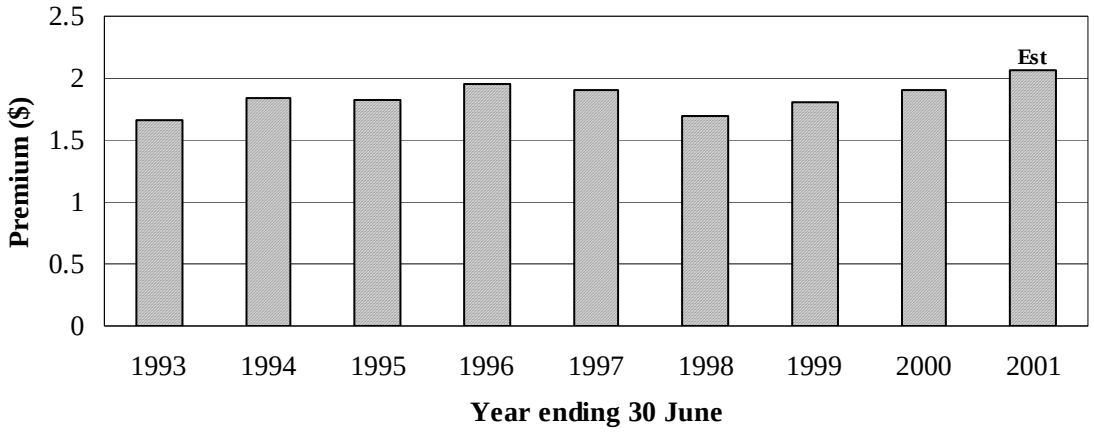
In a recent report using information from a sample of insurers on policies that were renewed between June 2001 and May 2002, the ACCC reported average premium increases of 22 per cent for 2001-02, with a minimum of 10 per cent and a

maximum of 42 per cent for individual insurers (2002b, p. 38). This compares with an average increase of 15 per cent experienced in 2000-01.[9]

Treasury noted that comparing the cost of premiums to GDP provides an indication of 'affordability' which takes account of inflation and economic growth (figure 2.4). Using this measure, Treasury said that the cost to the community of public liability premiums has averaged around 0.2 per cent ($2 per $1000) of private sector GDP since 1993. Treasury noted that this measure:

- increased slightly from 1993 to 1996;
- declined from 1996 to 1998 as premiums fell;
- returned by 2000-01 to a level above that of the mid 1990s; and
- is expected to be around 30 per cent higher in 2001-02 than in 2000-01 (2002, p. 3).

Figure 2.4 **Public liability premiums per $'000 of private sector GDP**



Source: Trowbridge (2002a, p. 25) drawing on APRA *Selected Statistics on the General Insurance Industry* (various issues).

In its September 2002 report, the ACCC said that, because of increasing premiums, public and product liability insurance continues to show signs of recovery. Indeed, the ACCC has upgraded its assessment of the outlook for public and product liability insurance from 'very low' (indicating that the return on capital may be unsustainable, requiring either increased premiums or exit from the market) to 'low'

9 Other areas with high premium increases were fire, industrial special risks and professional indemnity. In contrast, increases for householders' policies, domestic motor vehicle, CTP and employers liability were all 6 per cent or less (2002b, p. 38).

(indicating returns on capital insufficient to provide a margin above returns on risk free investments to compensate for the risk involved in insurance) (2002b, p. vii).

Data difficulties

While the broad outline of events is relatively clear, claims data are difficult to interpret because:

- public liability insurance is often provided in combination with other insurance; for example, public and product liability are often sold together, and this is reflected in the claims data available from APRA;
- available data only cover general insurers licensed with APRA (hence business directed offshore by brokers, or underwritten by mutual companies, is excluded);
- thresholds ('deductibles') for self insurance rise and fall with the state of the insurance market, meaning a varying proportion of smaller claims will be excluded from insurer-based statistics;
- APRA claims data have, to date, been collected incidentally to its main function of prudential supervision, and it has warned about the shortcomings of this data source;
- March 2002 revisions to APRA's data, which resulted in changes to their six-monthly 'Selected Statistics' publications from December 1998 to December 2000, may affect the conclusions drawn in reference material authored prior to March;
- data from Insurance Statistics Australia (ISA) only cover ISA members, which represent around 20 per cent of the industry, and its membership has changed over time; and
- data on premiums reflect that some companies set low premiums to buy market share rather than to reflect the cost of the risk being underwritten and that some insurers may have under-priced premiums during most of the 1990s (Trowbridge 2002a, p. ii).

As Trowbridge pointed out, insurers have 'not had a comprehensive industry-wide system to make relevant information available across the industry' (2002a, p. 40). Treasury, in evidence to the Senate inquiry, said that 'the government agrees that the data are inadequate' and has directed APRA to collect claims data (Senate 2002b, p. E329). It saw inadequate data on claims costs as a significant constraint to the appropriate pricing of premiums for not-for-profit, adventure tourism and sporting groups, and to the development of insurance products suitable for these sectors. The Institute of Actuaries agreed:

> … [insurance companies] can only look at the data for their own portfolio, which may be very small in some cases. They would certainly benefit from having access to a wider body of data to help them with their pricing. (Senate 2002b, p. E282)

The Senate Committee concluded that:

> … not only insurance companies but the market place as well should have access to industry-wide data so they can better assess risk and premium pricing. (2002d, p. 81)

APRA is now examining a methodology that might be appropriate to this end (Senate 2002b, p. E329). However, the establishment of a comprehensive database will take several years to come on-stream and accumulate enough data to make meaningful comparisons across time (Senate 2002a, p. E133). Insurers agreed that compulsion would be needed to ensure that firms submit the required data to APRA for the expanded database. Some argued that mutuals and government insurers should also be covered by the database. The Senate Committee said that statistical information about foreign insurers should be a necessary component of the database (Senate 2002d, p. 82).

FINDING 2.3

Public data on public liability insurance and claims are incomplete and potentially misleading. There is widespread acceptance of the need for better industry data, and processes have been set in train to achieve this.

Claims experience

Recent reports by Trowbridge and the ACCC appear to have provided the best data to date. Subject to the qualifications mentioned earlier, the broad picture they present is that, for insurers:

- claim numbers have been rising, but only slowly, and claim frequency (claims per policy or per dollar of premium) has probably remained fairly steady;
- the average size of claims has risen more rapidly, and across all claim size categories;
- most of the increase has been in bodily injury claims; and
- there has been some variation between jurisdictions in claims increases.

Numbers of claims

Based on a sample of insurers, the ACCC said that:

> The number of claims has … generally trended upwards over the period, averaging about 3 per cent per annum from 1995 to 2001, although this is significantly below the rate at which policy numbers have been increasing. (2002b, p. 59)

It also noted that the number of policies increased by about 7 per cent per annum over the five year period. The ACCC considered that various government requirements for contractors to be insured had contributed to the increase:

> It is not surprising that total premiums did not increase at the same rate as the issuance of policies as it is expected that the new policy covers would be for the smaller enterprises and consultancies and, hence, the average premium would decrease. (2002b, p. 57)

Data on claims reported to the Health Insurance Commission (HIC) for the purposes of its Compensation Recovery Program[10] show that the number of claims which were classified as either 'common law' or 'public liability' cases[11] reaching judgment or settlement fell from 1999-00 to 2000-01 and rose in 2001-02, but to a level still below 1999-00.

The Australian Plaintiff Lawyers Association, using APRA data (which is subject to the difficulties mentioned above), said that, as a proportion of the number of policies, claim numbers had exhibited only a small increase — from 2.64 claims per 100 policies in 1996 to 2.71 in the 12 months to June 2001 (APLA 2002, p. 16). It added:

> The experience of our members indicates that there has not been an increase in the number of claims handled by them in the relevant period. (p. 16)

Trowbridge reported that claims frequency has been 'fairly flat' over the period 1993 to 2000, moving in a band of approximately 7 to 10 claims per $100 000 of premium income for ISA members (2002a, p. 13). On this basis, the number of claims fell steadily from about 10 per $100 000 in 1995, 1996 and 1997 to about 8 in 2000. Trowbridge said that, while changes in the number and business mix of ISA members (a small group with changing membership) distort the observed trend:

> A small amount of data we have from individual insurers tends to confirm this — no overall increase in claim numbers, perhaps some reduction in recent years. (2002a, p. 13)

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10 This program requires the HIC to be notified of all personal injury claims for the purposes of recovery of amounts paid out under Medicare. From 1 January 2002, cases where the amount of compensation paid is $5000 or less are excluded from notification.

11 The categories to which cases are allocated are determined by the person providing the information, without guidance by the HIC. The extent to which they correlate with 'public liability' as used in this report is unclear.

But it noted that these observations probably do not indicate a favourable trend because:

- increasing levels of deductibles have reduced the number of claims received by insurers and contributed to the flat trend, as even a small deductible can eliminate many claims; and
- the mix of claims seems to be changing, with fewer property damage claims but more bodily injury claims (p. 13).

Trowbridge added that evidence from a group of local governments showed a sharp increase in the number of public liability claims made against the councils in 1996-97 and a continuing gradual upward trend since then (from a little over 700 claims in 1996-97 to a little over 800 in 2000-01) (2002a, p. 14).

Average claims size

There has been a significant rise in the average size of claims to insurers. For the ten years to 2000, Trowbridge found that, based on ISA data, the average size of claims increased by about 10 per cent a year (2002a, p. 16), whereas consumer prices rose by an average of 2.2 per cent a year, and wages by 3.2 per cent a year, over that period.[12] Trowbridge added:

> Other information available to us from individual insurers confirms an increase in the average size of claims over the 1990s. While it is difficult to get a precise measure of this increase, the available evidence is that the average size of claims has increased at a rate at least 5% p. a. higher than community inflation (taken as being [average weekly earnings]). (2002a, p. 16)

The increase in the average size of claims is supported by the ACCC. In its September report, it said that, for public and product liability policies, the average settlement size increased by about 8 per cent per annum in real terms from 1995 to 2001:

> Most of the observed increase relates to the period from 1996 to 1999 during which time the average cost of claims increased at 12.6 per cent per annum. (2002b, p. 59)

It added that the average claim size for 2002 (at $15 300) is likely to be about 3 per cent in real terms above that for 2001 (p. 59).

Independent data obtained by the Commission on the amounts paid out on personal injury claims advised to the HIC provide some support for Trowbridge's analysis.

[12] A 10 per cent annual growth rate means that the cost of bodily injury claims doubles around every seven to eight years.

The data reveal an average increase of 14 per cent a year in the cost of personal injury cases between 1999-00 and 2001-02.

Trowbridge reported that the increase in the average size of claims was largely due to increases in bodily injury claim costs. These increases are not a new phenomenon — they have been occurring for over 20 years or so, across all sizes of claims, not just the largest ones (Trowbridge 2002a, pp. i–ii, 7). This is supported by State and Territory data collected by Trowbridge, which show that:

- all jurisdictions have experienced an increase in the size of bodily injury claims in excess of inflation;
- the rate of increase appears to be higher since the mid-1990s; and
- New South Wales (and the ACT) have higher average bodily injury claims than other jurisdictions. In 2001, their average bodily injury claim was around $50 000, compared with $30 000 in Queensland and about $20 000 in other jurisdictions (2002b, pp. 61, 75).

HIC data also show that New South Wales had the highest average settlement in 2001-02 at just under $100 000, considerably higher than all other States and Territories. The average settlement amounts for Victoria, South Australia, ACT and the Northern Territory were under half that for New South Wales.

Over time, property damage claim costs have remained relatively stable. Bodily injury claims now make up the bulk of the cost of public liability claims, even though they number fewer than property damage claims (table 2.2). Moreover:

- 60 to 70 per cent of bodily injury claims are for amounts under $20 000, but they represent only 7 to 15 per cent of the total value of bodily injury claims; and
- some 70 per cent of the cost of bodily injuries is for claims between $20 000 and $500 000.

Table 2.2 **Public liability claims by type**

Type of claim	*Proportion by number*	*Average size*	*Proportion by cost*
	%	$	%
Property damage	75	5 000	35
Bodily injury	25	25 000	65

Source: Trowbridge (2002a, p. 12).

As noted for the number of claims, increases in the level of deductibles in recent years will have shifted some (mainly smaller) claims away from insurers. This will have inflated the average size of claims reported.

Concluding comments

As noted earlier, the Commission has relied heavily on industry-wide data produced by Trowbridge and the ACCC. Notwithstanding its acknowledged limitations, participants in this study raised no major objections to use of this data by the Commission. Their findings with respect to the increases in bodily injury costs and differences between jurisdictions in settlement amounts were supported by independent data obtained from the HIC.

The Commission also sought to obtain additional information by way of a short questionnaire sent to the main providers of public liability insurance, asking about their claims experience and the costs they incur in managing claims. While some were able to provide limited data, most had difficulty in providing it all. For example, some insurers were unable to provide a split between personal injury and property damage claims. One annotated its questionnaire with the comment 'The quality of data in the HIH systems is questionable and has therefore been excluded'. Some did not provide data on the cost components of claims management, or on the total costs incurred.

2.5 Regulation of insurance

Commonwealth responsibilities

Section 51 of the Constitution empowers the Commonwealth to make laws with respect to:

> Insurance, other than State insurance; also State insurance extending beyond the limits of the State concerned.

Section 51(xiv) empowers the Commonwealth to prescribe conditions upon which any person may carry out insurance business of any kind and establish any mechanisms for the supervision of such persons and corporations and to regulate their affairs.

The Commonwealth uses this power to regulate general insurance by way of:

- the *Insurance Act 1973*, which authorises companies to conduct general insurance business;
- the *Insurance Contracts Act 1984*, which regulates the relationship between the insurer and the insured;

- the *Insurance (Agents and Brokers) Act 1984*, which legislates the expected behaviour and relationship of agents and brokers with insurers and policyholders; and
- following passage of the *Financial Services Reform Act 2001*, the *Corporations Act 2001* provides for consumer protection aspects of the marketing of insurance.

Commonwealth legislation does not set or limit general insurance premiums (other than for health insurance). Insurers for public liability are relatively free (compared to some insurance classes such as CTP and workers' compensation) to compete on terms and conditions of covers as well as on price and service (ACCC 2002a, p. 59).

Other relevant Commonwealth legislation includes:

- the Health and Other Services Compensation Act (to prevent passing of costs onto Medicare); and
- Trade Practices Act requirements with respect to such matters as the duty of care to customers and users of products.

APRA provides prudential oversight of the insurance industry. In July 2002, it introduced new prudential requirements, discussed further in chapter 3, including re-authorisation of every general insurer seeking a licence to operate after 30 June 2002.

State and Territory responsibilities

Constitutionally, State and Territory Governments have the power to:

- own and operate insurance companies (while some previously state-owned insurers have been privatised, workers' compensation and CTP are provided by government agencies in some jurisdictions, even though claims management may be contracted out);
- regulate state-based insurance by, for example, setting maximum amounts on claims, establishing procedures for the handling of claims and setting price controls on premiums; and
- regulate and set premiums for certain types of compulsory insurance, primarily workers' compensation insurance and CTP (Kehl 2002, pp. 11–12).

State governments may also prescribe that certain professions and organisations obtain certain types of liability insurance as a precondition to operating or providing a service.

Across state jurisdictions there are variations in respect of matters such as the time during which a claim may be made, court rules, the length of waiting lists, the availability and effectiveness of alternative dispute resolution arrangements and legal fees payable. In addition, regulation of contingency fees ('no win, no fee'), class action lawsuits and advertising by lawyers differ among jurisdictions. To the extent that differences in legal processes between states have an impact on the manner in which claims are handled, they are discussed in chapters 4 and 5.

Recent developments

Following the Ministerial forums held during 2002, governments reviewed policies and procedures in their jurisdiction. As a consequence, at December 2002:

- the Commonwealth Government had introduced into Parliament amendments to the Trade Practices Act to give force to waivers in the case of high risk activities; and
- New South Wales and Queensland had passed new public liability legislation to limit payouts in some areas, restrict liability and facilitate procedures for claims management. For example, the Queensland act introduced mandatory pre-court procedures similar to those operating under Queensland's WorkCover Act and its Motor Accidents Insurance Act. Broadly, claimants are required to give notice before commencing proceedings and then must take part in alternative dispute resolution processes, including the requirement that all parties provide documents and other information at an early stage.

Other states were at varying stages of the review process.

The legislative changes will influence the scope of public liability claims and, hence, the cost and availability of public liability insurance. Some will also have implications for claims management procedures. These matters are considered further in chapters 4 and 5.

3 Public liability insurance — market characteristics

The Commission's review of the market characteristics for the provision of public liability insurance confirms APRA's and the ACCC's assessment that there are a sufficient number of providers for there to be effective competition. This view is reinforced when due consideration is given to the relatively low barriers to entry (and exit) that exist to this line of insurance, the ability to write business offshore, the scope to establish insurance pools with similar entities and the ability to self insure for some or all of the public liability risk. As a result of these competitive pressures, there are strong commercial incentives for insurers to seek out and adopt cost-effective claims management practices.

With the collapse of HIH, which accounted for 24 per cent of the public liability insurance market by premium revenue in the year to 30 June 1998 (ACCC 2002a, p. 102), significant capacity was removed from the public liability insurance market. In addition, other insurers have been reluctant to underwrite some of the risks that were formerly covered by HIH, especially at pre-existing premium levels. Concurrent with the reduction in supply, premiums have risen steeply for many customers, while others have experienced difficulties securing cover.

These developments have fuelled debate about the level of competition in the public liability insurance market (see box 3.1). While some industry participants believe competition is vigorous, others have expressed concern that any cost savings from reforms may not be passed on in insurance premiums. For example, the Australian Plaintiff Lawyers Association (APLA) said:

> … insurers do not want to change our compensation system to reduce premiums, but for ulterior motives. The proposals to cap damages or introduce thresholds is an attack on citizens' rights and will have no impact on the cost of premiums. (2002c)

Given these concerns, it is useful to look at the insurance market and survey the level of competition, including contestability by potential entrants. This helps assess the extent to which commercial incentives exist to encourage insurers to adopt efficient practices, including claims management strategies. This involves considering the particular market characteristics that indicate the likely strength of competitive pressures on insurers. The following sections examine market

definition and structure (section 3.1), barriers to entry and exit (section 3.2) and other market conditions (section 3.3). Investigating the profitability of firms in the market and their pricing behaviour (section 3.4) also gives some insights into the level of competition.

Box 3.1 **A selection of views on the state of competition**

The Australian Competition and Consumer Commission:

> Our view is that the industry was reasonably competitive during much of the nineties. It has obviously hardened somewhat over the last 12 or 18 months and it is rather less competitive now, particularly in public liability and professional indemnity insurance … we can see a distinct possibility that some insurance companies will move back into those areas of insurance when they perceive that their potential exposure will be less than it was previously. At the moment it is a bit hard to make a call on exactly how competitive or otherwise the industry is, because it is in the process of transition. (Senate 2002a, p. E124)

The Treasury:

> It is certainly the case that the barriers to entry in the industry are not high. That is not necessarily undesirable, because it means the degree of competition in the industry should be reasonably high and therefore, other things being equal, the premiums charged should be competitive ones. (Senate 2002b, p. E329)

The Australian Prudential Regulation Authority:

> It is actually in our charter to balance safety against competition … at the moment we would like a little bit less competition and a little bit more safety. (Senate 2002a, p. E144)

The Institute of Actuaries of Australia:

> Part of the problem with the insurance market is that … there are very low barriers to entry and it is a very competitive market. (Senate 2002b, p. 284)

The Australian Plaintiff Lawyers Association:

> … there is an absence of competition in the Australian insurance industry. That is the only thing which is going to reduce premiums, short of regulation of premiums, which of course nobody really wants. (Senate 2002a, p. E150)

The Law Council of Australia:

> If there is still a lingering problem about insurance capacity then it is likely to be remedied by the apparent increasing profits from this type of insurance that the industry will enjoy in the coming year. (Senate 2002b, p. E269)

3.1 Market definition and structure

Market definition

In defining the market, the aim is to:

> … encompass firms which are sufficiently in competition so that a price increase by one would cause a significant number of customers to switch to another firm or would elicit a competitive response from existing firms. (IC 1995, p. 43)

This notion of the market would include firms selling the same product, whether domestic or offshore, and firms selling close substitutes.

This study is ultimately concerned with the link between claims management practices and the affordability and availability of public liability insurance, as stated in the terms of reference. This suggests a narrow market definition focusing on insurers, for whom the cost of claims management directly affects underwriting activity.

Consequently, the Commission has defined the market as being Australian insurers (that is, firms operating under Australian regulation). As the pool of actual and potential public liability insurance underwriters comes from the general insurance market, the analysis looks at both general insurance operations and public liability insurance operations undertaken by these firms. Mutuals and offshore insurers operate outside regulatory boundaries and there are little data available on their activities. For these reasons, they are excluded from the analysis (see box 3.2 for a brief discussion of offshore insurers). Specialist claims management firms, brokers and any claims management activities undertaken by insured parties are also excluded.

Box 3.2 **Insuring offshore**

In principle, insuring offshore should be a viable option for many Australian firms and organisations:

- The global insurance market is huge, with Australia's 41 million insurance policies and 3.4 million claims each year accounting for just 2 per cent of the total market (Harvey 2002).
- The market is relatively easy to access — brokers regularly arrange insurance with offshore insurers.
- As several large jurisdictions, such as the United Kingdom and the United States of America, also operate under common law legal systems, some large foreign insurers have experience in offering public liability products similar to those offered by Australian insurers.

Market structure

Most Australian insurers sell public liability insurance, although for many it is sold as a component of home and contents policies rather than as a stand-alone product (ACCC 2002b, p. 43). Insurers which offer stand-alone public liability insurance tend to specialise in particular areas of the market, such as small and medium sized enterprises, large commercial enterprises or 'frequency accounts' such as shopping malls.

The biggest providers of public liability insurance in the domestic market are IAG (including NRMA), QBE and Suncorp-Metway (ACCC 2002a, p. 96). IAG writes public liability predominantly as a component of household insurance policies. The ACCC's survey of 16 insurers found that, measured by premium income, 13 insurers accounted for 63 per cent of the public and product liability insurance market (2002b, p. 54). In 2001, these 13 insurers wrote some 1.5 million public and product liability policies and collected almost $600 million in premiums.

In the general insurance market as a whole, the largest ten insurers accounted for around 72 per cent of the market in 2001 (ACCC 2002b, p. 5). IAG was again the biggest player, with 18 per cent of the market, as measured by premium income. Royal & Sun Alliance accounted for 12 per cent of the market, while the third biggest player was CGU, with 8.5 per cent of the market.

Formal interpretations of market share data indicate that there are no serious concentration concerns about either the public liability insurance market or the general insurance market. Using the Herfindahl-Hirschman index (box 3.3), the ACCC found that, while there has been an increase in concentration in the general insurance industry since 1997, a substantial degree of competition remains (2002b, p. 5). For the combined public and product liability market, the ACCC found a substantial *decrease* in concentration since 1997, although the 2001 level was a little higher than that in the general insurance market (2002b, p. 46).

This test suggests that the market structures in the general and public liability insurance industries are not overly concentrated and, in themselves, do not give rise to concerns about a lack of competition. Consistent with this, APRA suggested that, in terms of the finance industry, general insurance is actually one of the more competitive areas:

> There are 111 companies now writing new business in the general insurance industry and the entry hurdle is $5 million. In the banking industry, for example, the entry hurdle is $50 million of capital and there are 40 to 50 companies. In the life insurance industry, the entry hurdle is $10 million of capital and there are 40 to 50 companies. Both the banking and life insurance industries are far greater in size than the general insurance industry, so you would have to conclude that across the spectrum of the

financial sector the general insurance industry is one of the more competitive parts. (Senate 2002a, p. E133)

Box 3.3 **Interpreting market share data**

The Herfindahl-Hirschman index (HHI), or concentration ratio, shows the degree to which an industry is dominated by a small number of large firms. The index is calculated by taking the sum of the squares of the market shares of each firm in the industry. The US Department of Justice guidelines suggest that an HHI of over 1800 is indicative of concentration in a market.

However, care must be taken in interpreting market share data. A high market share is only a reliable indication of market power when there are no significant alternative sources of supply, no substitutes, and little possibility of new entrants (IC 1995, p. 52). In addition, the cyclical nature of the insurance market suggests that any market power is likely to be temporary.

The public liability market is only slightly more concentrated than the general insurance market as a whole, and may also be regarded as competitive.

3.2 Barriers to entry and exit

Barriers to entry and exit refer to factors that prevent market forces from eroding an industry's excess profits over time. With no (or low) barriers to entry and exit, new entrants will be attracted into markets where existing firms are earning excess profits or have inflated costs. In this way, competitive pressure is maintained on incumbent firms to operate efficiently.

Barriers to entry and exit may consist of regulatory barriers and/or market barriers. In the insurance industry, these barriers may occur both in the general insurance market and in the public liability insurance market.

Regulatory barriers

Once insurers are licensed to operate, they are required to comply with APRA's legislated prudential standards for insurers (see box 3.4). Some in the industry felt that the recently introduced requirements for greater capital adequacy may discourage insurers from writing public liability insurance, as the higher level of risk involved in public liability now necessitates having more capital. However, the extent to which this would act as a barrier to entry is not clear. While it is true that insurers writing public liability are required to hold more than the specified base

level of capital, many of the insurers were already holding higher amounts so as to maintain their credit ratings on international markets.

Box 3.4 **APRA regulation of insurers**

APRA is responsible for the prudential regulation of the insurance industry. Its role with respect to general insurers is:

> … to reduce the probability that an authorised insurer will fail to pay its contractual obligations to policyholders when due, and to reduce the severity of loss to policyholders should such a failure occur. (2002d, p. 2)

The prudential regime was revised and amended in mid-2002. Requirements for insurers are now set out in the *Insurance Act 1973* (amended) and accompanying regulations. The new prudential regime significantly strengthens the supervisory framework applying to general insurers in Australia.

The new standards, introduced on 1 July 2002, include requirements to:

- comply with APRA's new Liability Valuation Standard, which mandates actuarial advice and a prudential margin;
- possess a minimum level of capital of $5 million, with any capital requirement above this based on the 'riskiness' of each class of business. This may result in higher levels of minimum capital being held than previously; and
- have compulsory risk management systems, including pricing and underwriting control mechanisms.

All insurers must meet these standards and requirements in order to enter and remain in the insurance industry.

The *Insurance Act 1973* as amended also sets out requirements for firms wishing to exit the industry, with guidelines for the assignment of liabilities, transfers and amalgamations, and winding up.

There are no restrictions on the number, size or mix of operations of foreign-owned subsidiaries or branches operating in the Australian market. However, foreign insurers must provide evidence that their arrangements for reporting to their parent or head office are adequate, that they have received consent from their prudential supervisory authority to establish an operation in Australia, and that they are subject to adequate prudential supervision in their home country.

Sources: APRA (2002a, 2002b and 2002d).

The more crucial issue will be the willingness of shareholders to provide additional capital, if required. This willingness will be based on profitability and returns in the public liability insurance market. As noted in chapter 2, and discussed further in this chapter, the public liability insurance market has not been profitable for some time. The poor returns in this market may prove to be a more tangible 'barrier to entry'

than regulatory rules and requirements, with the ultimate number of players in the industry dictated by the underlying profitability of the business.

In any case, the extent to which APRA's regulations could pose a barrier to entry to the public liability insurance market is limited, as several groups of underwriting organisations are not captured by the Insurance Act and its accompanying regulations. In particular, offshore insurers and mutuals wishing to offer public liability insurance in the local market are not subject to APRA's oversight and are not bound directly by APRA requirements.

Overall, the ability of firms to enter and exit the Australian domestic market for public liability insurance appears to be relatively unrestricted by regulatory barriers.

Market/commercial barriers

In principle, there are a number of barriers to entry and exit that may arise because of commercial realities and market characteristics. For public liability, as well as the insurance industry generally, an important barrier is the risk of adverse selection. Another potential barrier arises from the skills acquired from 'learning by doing'. On the other hand, economies of scale and scope and sunk costs do not appear to act as major barriers. These factors and their influence on entry to, and exit from, the public liability insurance market are discussed in more detail below.

Adverse selection and 'learning by doing'

Adverse selection is an inherent problem faced by firms operating in insurance markets. It arises from the insured party knowing more about their own situation than the insurer. As the insurer cannot identify individual risks, it sets premiums that reflect the average risk of a group. As a rule, an insurer's capacity to assess risk and set appropriate premiums will tend to improve over time as the company gains experience and adds to its information base.

For an entrant, the risk of adverse selection poses a dilemma — pricing low to build market share may attract some customers who were previously self-insuring or some low-risk customers from other insurers, but it may also attract high-risk customers looking for a cheaper deal. As the entrant cannot tell the difference between these customers, it may end up relieving incumbent insurers of their bad risks and end up with a very risky portfolio.

The problem of adverse selection is exacerbated by a lack of publicly available data and information. Hence, while firms already operating in the market benefit from experience and knowledge built up over time, new entrants may have little to draw

on. In this sense, incumbent firms have a head start over potential entrants due to these 'learning by doing' effects. Naturally they are reluctant to share information with new entrants, since the information gives them a competitive advantage.

This shortfall in information can be a particular problem in some parts of the public liability market. For short-tail products, existing premiums provide reasonably current information on costs to new entrants, while other long-tail products, such as workers' compensation, have legislative requirements for data collection and dissemination that allow new entrants to assess the market. However, the long-tail nature of public liability insurance means that a clear picture of the cost of claims, and therefore the appropriateness of current premium levels, is not available until some years after the claim is made. Further, there are no industry-level data requirements beyond those imposed by APRA's financial reporting requirements. This makes it hard for potential entrants to assess the current profitability of the market and decide on appropriate premiums.

Because of the data limitations, entrants may choose to adopt the current market level of premiums, then feel their way towards a pricing regime that suits their business as they accumulate data and experience. Such an iterative approach may not appeal to all potential entrants. That said, potential entrants to many industries are disadvantaged by possessing less information than incumbent firms, and it is doubtful whether this difference can be construed as a significant barrier to entry.

Other potential barriers

Economies of scale and scope could deter entry if a potential entrant has to make a considerable up-front financial commitment to break into the insurance market or if entry has to be across a large number of products in the market for the firm to be efficient.

However, while important, economies of scale and scope do not present major barriers to entry to the public liability insurance market. Hurdles presented by economies of scale or scope can be mitigated in various ways. For example, insurers can join group buying schemes, where they can enter a contract to insure, say, 20 per cent of a pooled risk, with the other 80 per cent shared amongst other insurers. In the case of public liability insurance, it is also relatively easy for insurers operating in other spheres of the general insurance industry to build on their existing operations, draw on the experience of staff in related areas and expand into public liability insurance.

The ability to exit the market is also an important aspect of a competitive market. More specifically, entry is facilitated if potential entrants can, if circumstances

dictate, exit the industry at a later date at relatively low cost. Sunk costs (that is, costs that once incurred cannot be recouped) can make it more costly for a firm to exit a market, and therefore can act as a deterrent to entry.

However, sunk costs do not appear to be a problem in the public liability insurance market. Financial capital can be reallocated relatively easily if a firm wishes to withdraw from the market and the physical capital used for public liability insurance is non-specific (for example, computers). While experience and on-the-job training in the industry are important, human capital is also not a significant sunk cost for insurers.

3.3 Other market conditions

The analysis of market structure and barriers to entry presented in sections 3.1 and 3.2 suggests that the market for insurance remains competitive, with few barriers to entry and exit. This indicates that the supply of public liability insurance is not significantly constrained by a lack of competitive behaviour or difficulties in breaking into the market.

This contention is supported by the recent appearance of several new entrants in the public liability insurance market. IAG indicated it may begin to provide stand-alone public liability insurance, conditional on further legislative reform. In addition, Suncorp-Metway announced an expansion in its public liability cover, following its withdrawal of cover from around 200 of 2200 insured occupations last year (Morris 2002).

Further competitive pressure is placed on the public liability insurance market by consumers. When consumer demand is sensitive (or elastic) with respect to price, firms have less scope to act in an uncompetitive manner, as consumers will be willing to search for cheaper options.

At the level of an individual or firm, demand for public liability insurance may be relatively inelastic. For example, the Institute of Actuaries noted that:

> … these organisations [sporting clubs, show societies, volunteer organisations and common interest groups] have no choice but to insure, since the owners of the premises they use insist on insurance as a condition of that use. (2002, p. 9)

However, the extent to which insurers operating in the Australian market can exploit this is limited by a number of factors.

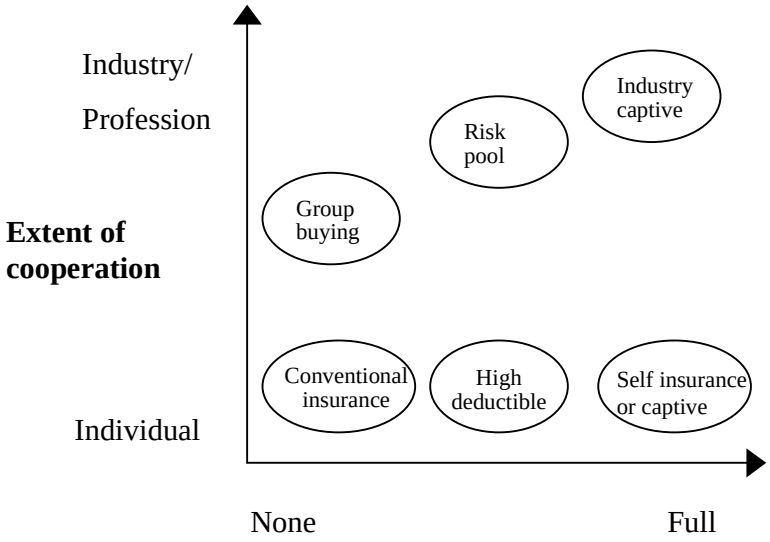
- While there is no other *product* available in the market that provides the same characteristics as public liability insurance, there generally remains a choice of supplier, and there are different options for its *provision* (see box 3.5). The

availability of these options increases the price sensitivity of insurance consumers and, therefore, increases the competitive pressures that consumers can apply to insurers.

Box 3.5 **Options for insurance provision**

For an organisation seeking public liability insurance cover, there are several supply options available. The option chosen is likely to depend on the size of the entity, the type of risk the entity faces, and the relationship the entity has with potential claimants.

Minty (2002) presented a 'map' of different options for risk transfer, ordered by the degree of risk the entity retains and the extent of cooperation within the industry or profession:



For a single firm, aside from the option of conventional public liability insurance, there are options to take a higher deductible or to fully self insure.

- Increasing the level of deductibles implies firms accepting more risk themselves. It may involve the firms managing those claims that fall under the deductible level themselves or contracting out this claims management function to a specialist firm.
- For some, it may be optimal to undertake full self insurance and simply take out catastrophe cover to protect against major adverse events. In this case, a firm would make provision each year for potential public liability claims, just as an insurer would. This option is more risky, as the firm does not benefit from risk pooling in the way an insurer can and bears the full risk of claims provisions being inadequate. However, some firms prefer to have more control over the way their insurance is handled, particularly if the claimant is a direct customer, and so opt for self insurance.

(Continued next page)

Box 3.5 (continued)

- Some firms may go to the extent of creating a fully owned 'captive' insurance company for their insurance needs, although this is probably only a viable option for large firms.

If firms are comfortable cooperating with other members of their profession or industry, they may choose to buy insurance as a group from an insurer, pool their risk via a mutual arrangement, or set up a captive insurance company for the industry:

- An insurance pool, where a group of similar entities approaches an insurer for group cover, may be an option for some. While the level and conditions of cover may not exactly suit the needs of all participating entities, it provides a bigger risk pool for the insurer and may increase the bargaining power of the group.
- Another option is to participate in a 'mutual' arrangement with other similar entities. Here, entities contribute to a central pool that is drawn upon in the event of a claim. While a mutual can provide similar cover to an insurer, there are fewer safeguards against failure. Mutuals are not regulated prudentially and are not required to comply with the accounting standards that apply to general insurance companies. In the case of the medical profession, Treasury noted that some mutuals (known as Medical Defence Organisations) have not provisioned for all of their liabilities. This has led to a 'tail' of liability (Senate 2002b, p. E322). APRA has particular concerns about mutual structures for insurance. It noted that:

  … in today's world they are a priori at risk of being inherently flawed and dangerously underfunded … such schemes only work if the common interests of the members result in a consistently below average claims experience … the natural incentive of such schemes [is] to keep subscription rates at unsustainably low levels. (Senate 2002a, p. E132)
- A group of firms may choose to set up an industry captive insurer, although this option would require significant levels of cooperation and trust.

For those opting to retain conventional insurance, there is also the option of looking for insurance cover from an offshore provider. For a fee, brokers will scan the international market for an appropriate policy at a price the consumer is willing to pay.

- As the share of public liability insurance in a firm's overall costs rises, the incentive to seek alternatives also increases. This puts further competitive pressure on insurers. For example, community-oriented groups, for whom insurance costs are likely to form a significant component of total costs, have been keen to arrange insurance through other means. One example is the Civic Mutual + scheme that was developed by the Municipal Association of Victoria as a mutual liability self insurance scheme to cover public and product liability. This scheme was recently expanded to include not-for-profits, and offers cover of either $5 million or $10 million (http://www.communityinsurance.com.au).

The availability of alternative sources of public liability insurance, and the cost incentives on individuals and firms to seek competitively priced insurance, supports

the finding that the public liability insurance market is sufficiently competitive to provide incentives for insurers to adopt cost-effective practices.

3.4 Profitability and pricing

Profits and pricing behaviour can also provide some insights into the competitiveness of the market. An enduring level of excess profits in the industry may indicate a lack of competition. Large price increases may also imply market power. An examination of these issues provides further evidence on the competitiveness or otherwise of the public liability insurance market in Australia. Profits and prices are discussed in turn below.

Profits

Insurers' costs generally exceeded premium revenue in the public liability insurance market from 1993 to 2001, with the industry relying on investment income to cover costs (or to reduce losses). The combined ratio, which is a standard industry measure of performance, compares premium revenue with claims costs (including payouts and expenses). The ratio exceeded 100 per cent for nearly the entire period 1993 to 2001 (ACCC 2002a, p. 48). Box 3.6 sets out the derivation of the combined ratio, which is an amalgamation of other performance measures — the expense ratio and the loss ratio.

Interpreting the individual components of insurers' costs in isolation can be difficult, as there may be a tradeoff between administrative expenses and payouts. In particular, cutting back on administrative costs (such as staff costs) and lowering the expense ratio may actually result in higher payouts and a higher loss ratio. Spending more on experienced staff and taking the time to conduct a thorough investigation may raise the expense ratio, but may also lower the amount paid out to the claimant, thus lowering the loss ratio.

Keeping this caveat in mind, for public and product liability insurance, the expense ratio fell from 35 per cent in 1998 to 30 per cent in 2001.[1] This compares to expense ratios for general insurance of 31 per cent in 1993-94 and 27 per cent in 2000-01 (ACCC 2002a, p. 20). These data suggest that, while expenses as a proportion of premiums paid have fallen for both general insurance and public liability insurance, public liability expenses have been higher than the average for all insurance products. This may partly reflect the characteristics of public liability

[1] Commission estimates based on APRA Selected Statistics for 1998, 1999, 2000 and 2001; tables 6 and 9.

underwriting, namely the individualistic nature of policies, the wide variety of claims and the difficulties of reaching agreement on both liability and the extent of damages. More 'straightforward' insurance products, such as motor vehicle insurance, are able to enjoy cost efficiencies from more standardised processes and procedures.

Box 3.6 **Combined ratios**

The combined ratio is an amalgamation of the loss ratio and expense ratio for an insurer. It is an indication of the overall profitability of a class of business, with a ratio in excess of 100 per cent indicating the insurer is relying on investment income on its reserves to generate profits. The loss ratio indicates the adequacy of premiums, while the expense ratio is one indication of operating efficiency.

Looking at an example, say XYZ Insurance has net earned public liability premium revenue of $1 million for the year. Claims are $0.9 million and expenses allocated to the public liability part of the business totalled $0.15 million.

The loss ratio equals the claims expense divided by the net earned premium.

For XYZ Insurance, its loss ratio would be as follows:

Loss ratio = $0.9m/$1m = 0.9 or 90%

The expense ratio is calculated as operating costs divided by net earned premium. XYZ has an expense ratio of:

Expense ratio = $0.15m/$1m = 0.15 or 15%

Thus, for XYZ:

Combined ratio = 0.9 + 0.15 = 1.05 or 105%

This suggests that XYZ is not earning enough premium revenue to cover its claims costs and operating expenses. It is relying on earning investment income to turn a profit.

Sources: ACCC (2002a, pp. 18–20); Commission estimates.

For the loss ratio, ISA data for public liability insurance for 1994 to 1998 showed that only one industry, 'welfare & community', was profitable in terms of covering claims expenses with premium revenue (Trowbridge 2002a, p. 34). All other industry segments were unprofitable, particularly 'unlicensed clubs' and 'hotel accommodation'. While the data are limited and relatively old, they do highlight that premiums were not sufficient to cover claims in this period.

Looking at overall profits, the ACCC's September report on the insurance industry concluded that the outlook for the Australian general insurance industry as a whole for the 2002-03 financial year is positive (2002b, p. xiv). However, profits in the public liability business have been low or negative since the mid-1990s. This is

shown by insurance trading results (ITRs) for the industry. Box 3.7 outlines the methodology behind ITRs.

Box 3.7 **Profits in the public liability insurance business**

Insurance trading results

The best indication of profitability in the industry is considered to be the Insurance Trading Result (ITR). This takes the profit or loss from underwriting, adds any investment income earned on reserves, and expresses the result as a percentage of premium revenue. According to the Insurance Council of Australia, an ITR of between 6 and 10 per cent is required to provide a reasonable return on capital for the public liability business.

Picking up the earlier example of XYZ Insurance (earning $1 million in public liability premiums for the year, paying out $0.9 million in claims, and having public liability operating expenses of $0.15 million) — say they increase their provision for outstanding claims by $0.1 million (as their estimation of what they might have to pay out on yet-to-be-settled claims has gone up), and that public liability's share of investment income came to $0.18 million.

XYZ's ITR for public liability would be as follows:

Underwriting result = premium revenue – claims – increase in provisions – expenses

= $1m – 0.9m – 0.1m – 0.15m = –$0.15 million

ITR = (–$0.15m + 0.18m)/$1m = 3%

By the Insurance Council's guidelines, XYZ Insurance does not seem to be making a reasonable return on its capital in the public liability business.

Sources: Trowbridge (2002a, pp. 31–4); Commission estimates.

The ISA show profitability, as represented by ITRs, for public liability insurance turning negative in 1994 (Trowbridge 2002a, p. 33). ISA data allocate the cost of claims back to the 'accident year' and therefore give a more accurate picture of the profitability of the underwriting undertaken within a given year. They suggest that, for one reason or another, policies were not being matched with appropriate premiums.

Using APRA data to calculate ITRs, Trowbridge showed that insurers had positive returns from 1993 to 1996, a small negative return in 1997, and then strongly negative results through to 2001 (2002a, p. 32). However, APRA's figures have some shortcomings for use in these calculations, as they are based on financial year operating data. Any under-reserving or over-reserving for future claims will skew the reported ITR and will give an inaccurate picture of the profitability of business written in a given year.

This said, these statistics on insurer profitability suggest that public liability insurance has not been a profitable undertaking for insurers for some time.

Further evidence on the profits of public liability insurers is provided by the ACCC. It estimated that the return on capital for public and product liability fell to a low of around –47 per cent in 1999, recovering to about –12 per cent in 2001 (2002b, p. 24). It suggested that returns in the public liability class of insurance are currently 'very low', with an outlook for 'low' returns on capital of between –5 and +10 per cent (2002b, p. vii).

The return on capital for this line of insurance, while still negative, has continued to trend upwards since the March 2002 review:

> The expectation is for the recent premium increases to restore this class to a profitable level. However, … the return on capital at 30 June 2002 is still likely to be negative as further adjustments to balance sheet provisions are reported. (2002b, p. 24)

Any shift towards excessively high premiums is likely to be constrained by competitive pressures, in particular, the possibility of entry.

Prices

While the evidence from 1993 to 2001 suggests that prices were not covering costs, the increase in premiums in recent months has led to some accusations of 'price gouging' against insurers. The assertion is that higher prices are an attempt by insurers to recoup past losses (box 3.8 presents some recent opinions on this issue).

As noted in chapter 2, average premium rates fell over the period 1993 to 1998 as insurers competed for market share, then rose as the market tightened (Trowbridge 2002a, p. 27 & APLA 2002a, p. 5). In early 2002, premium rates (for public liability and product liability combined) were still only 90 per cent of their 1993 level (APLA 2002a, p. 7). While data on average premium rates certainly lack precision, they do give an indication of the general movement of premiums. Trowbridge estimated that premium rates would have increased by 32 per cent on average in the year to 30 June 2002, with approximately 14 percentage points attributed to the effects of the 11 September disaster (2002b, p. 26). However, even with the premium increases, the ACCC has estimated that returns in the public liability market would be low over the next year.

At the same time, the demand for public liability insurance policies increased. The number of policies issued over the 1993 to 2001 period rose, on average, by 8.4 per cent a year (ACCC 2002a, p. 15).

Box 3.8 **Price gouging?**

The Australian Competition and Consumer Commission:

> Any insurer seeking to recover past losses will further add to the observed percentage premium increase. Competition between insurers will tend to limit the extent this can be done. Overcharging will attract new entrants or insurers with a strong capital base to charge more realistic premiums. (2002a, p. 105)
>
> If losses, at least in part, result from premiums having been too low in the past, you could reasonably make an argument that the recoupment at least of some of those losses through high premiums may not necessarily be all that unfair a thing … To the extent that you can say that these past losses are the result of financial mismanagement or poor financial judgment, you can make a very respectable argument that it is ultimately the shareholders in a particular company that should bear that loss rather than the customers of the company … the more competitive an industry is, the scope — particularly for an individual firm within the industry — to price so as to make up for past losses would be correspondingly reduced. (Senate 2002a, p. E119)

The Australian Prudential Regulation Authority:

> A key aspect of APRA's perspective on this issue is that we do not see higher premiums as either necessarily undesirable or completely avoidable. The most important protection a policyholder can have is the survival of the insurer, as a failed insurer cannot pay claims… From our perspective, rising premium rates, due to both cyclical and one-off factors, are necessary if industry profitability is to start climbing back towards viable levels. This is not a matter of clawing back past losses, but rather of ensuring future viability. (Senate 2002a, pp. E130–1)
>
> We have seen no evidence of price gouging … I do not see how you could get away with that with so many companies in this industry. (Senate 2002a, p. E145)

The Institute of Actuaries of Australia:

> … if there is a perception among other potential insurers that some insurers are trying to recoup losses, they will rapidly jump in and try to take advantage of that by cutting their prices and earning profits. (Senate 2002b, p. E284)

The Treasury:

> Certainly we have not seen any evidence that there has been price gouging, particularly in these classes of insurance. The reasons that we have to suspect that that is unlikely to be the case are the level of profitability in the industry, the number of players in the industry and, as we were talking about before, the low barriers to entry. (Senate 2002b, p. E333)

Australian Plaintiff Lawyers Association:

> Insurers in a competitive marketplace reduce premiums in response to price competition. Most will incur significant losses to prevent the erosion of their market share. These losses have to be recouped when competition declines. (2002a, p. 9)

The recent increases in premium rates appear to reflect the fundamental reassessment of the costs of underwriting public liability risks that has occurred, rather than being the result of anti-competitive coordinated conduct among insurers. It is also unlikely that prices in the market would be forced up as a result of

coordinated conduct between firms. As the ACCC merger guidelines suggest, the potential for anti-competitive coordinated conduct in a market is higher when there are a small number of firms, few potential entrants, inelastic demand, homogenous products, homogenous firms, transparent pricing, vertical relationships and strong industry associations (1999, pp. 58–9). As indicated above, on the balance of these measures the level of competition in the market appears sufficient to limit the scope for coordinated anti-competitive conduct.

Competition 'coordinates' market conduct to the extent that insurers react to competitors' prices, particularly during the soft (or cheap) part of the insurance cycle. This type of conduct, which is a feature of many other markets, could perhaps be more appropriately seen as 'conscious parallelism', as firms attempt to match or better competitors' prices to maintain or gain market share. The potential for this to cause institutional instability in the public liability market should be reduced as a result of the new APRA regulations, which took effect in July 2002.

Overall, the Commission considers that the public liability insurance market in Australia remains competitive, with low barriers to entry and exit. The recent behaviour of firms is consistent with the current environment they are operating in — low or negative profitability in the public liability insurance market has required a tightening of policy conditions and increased premiums. The ultimate shape of the market will depend on the profitability of the underlying business. As profitability improves, firms will have more incentive to enter the market.

FINDING 3.1

The public liability insurance market remains reasonably competitive, new players may commence underwriting public liability risks at any time, and customers can insure overseas or self insure. There appears to be sufficient competition to provide normal commercial incentives for insurers to make their claims management practices efficient and cost effective.

4 Claims management practices

The claims management practices of Australian insurers are examined in more detail in this chapter. As a key part of providing public liability insurance, insurers' aim with claims management is to deliver the contracted cover in an efficient and cost-effective manner. The processes they use for handling claims are heavily influenced by legal processes and precedents, as the establishment of liability and the quantum of damages are determined within the adversarial common law system. Insurers focus on containing costs and settling claims quickly as costs (in particular, legal costs) increase noticeably as the time taken to settle claims increases. While the broad steps involved in claims management are fairly common across the industry, the processes of individual insurers vary because of differences in the types of public liability risks underwritten and portfolios of risks held. Insurers' international linkages, such as through ownership and reinsurance arrangements, encourage the awareness and adoption of any overseas practices that could improve their operations. While they maintain sufficient data to manage claims effectively, questions remain about some insurers' use of that data for purposes such as internal premium setting and risk analysis, and for accident prevention by policyholders.

This chapter looks in more detail at the claims management practices of Australian insurers of public liability. It outlines existing practices and compares them with views expressed about best practices. The chapter examines: insurers' strategic and operational approaches to claims management (sections 4.1 and 4.2); feedback loops relating to performance, process and risk (section 4.3); and insurers' management of data and use of technology in processing claims (section 4.4).

4.1 Strategic approaches to claims management

In designing their claims management processes for public liability, insurers need to consider:

- the objectives for claims management;
- the organisational design which will deliver those objectives; and

- the key features to underpin the claims management process.

How Australian insurers have approached these issues and participants' views on 'best practice' for this initial strategic stage of claims management follow.

Setting objectives

Claims management is a key part of an insurer's activities and can be a source of competitive advantage. As such, the claims management process could be expected to be one of the focal points of an insurer's business strategy. However, few insurers mention claims management in their mission statement, key objectives or strategy. While most have a statement of 'vision', 'strategic objectives' or 'strategy', these tend to be broad expressions of commitment to shareholders, customers and staff. Some refer to 'operational efficiency', but few note claims management explicitly. (Although, this may be implied, to the extent that efficient claims management is seen as a prerequisite for the achievement of stated objectives.)

Most insurers said 'keeping costs down' was the major objective behind their claims management process. In practice, this often boils down to settling claims as quickly and cheaply as possible, largely because costs (and, in particular, legal costs) tend to increase noticeably as the time taken to settle claims increases.

It is important to see this cost objective in context. Insurers operate in a common law environment heavily influenced by legal processes and precedents. They have a responsibility to earn a return on capital for their shareholders and to provide good quality services to their insured parties. A focus on costs and quick resolution of claims can help achieve both objectives.

The manner by which public liability claims are resolved is relatively unconstrained by legislation. In contrast, specific statutes cover motor vehicle compulsory third party (CTP) and workers' compensation and dictate some processes and procedures to be undertaken when handling claims. Consequently, insurers in those fields must also incorporate legislated requirements for injury management and 'return to work' procedures into their claims management objectives.

Cost-effective claims management seems an appropriate objective for insurers to set for their claims management operations. As one broker put it, 'insurance is a promise — insurers must pay people what they are entitled to under the conditions of their insurance contract'. The aim should be to achieve this in a cost-effective manner. However, some in the industry cautioned that, as claims management feeds into underwriting and marketing, a claims strategy should also focus on quality and

the adequate resourcing of staff for managing claims. They felt that a simple expense reduction mindset was not the answer. These matters are discussed further later in the chapter.

The focus on containing costs and settling claims quickly was also emphasised by specialist claims managers and self insurers. One said that its average claims costs for litigated claims increased by some 15 per cent a year, and this provided a strong encouragement to resolve claims quickly. As self insurers' claimants are often their customers, this provides added incentive to resolve claims expeditiously.

Deciding on an organisational design for claims management

There are several choices available to insurers:

- Claims may be managed in-house, using either specialist public liability staff or staff drawn from other liability areas, such as CTP or workers' compensation.
- Claims may be assigned to a specialist claims management firm. The number of these firms operating in Australia has increased in recent years. One insurer noted that American claims firms already have extensive experience in dealing with different local environments, due to the differences between jurisdictions in the United States of America.
- Claims may be handled by insurance brokers, who appear to be increasingly seeking to become involved in claims management.

The major insurers interviewed by the Commission all manage their claims in-house as they prefer to maintain control of claims on policies they have written. They also consider their methods are more cost effective than those employed by external managers and believe they have sufficient skills within their organisations to manage claims cost effectively.[1]

Some insurers allocate public liability claims to their CTP staff because of their experience in common law and personal injury, while others prefer to have a specialist public liability team (particularly if they have a specialist public liability book). Other insurers have combined public liability/professional indemnity teams. The team structure largely depends upon the nature and size of the public liability business handled by the insurer and the other types of insurance they currently undertake.

[1] For any outsourced claims handling, insurers would be required to meet APRA's risk management principles for outsourcing (APRA 2002f). These cover such matters as assessment of providers, the nature of agreements entered into and contingency plans.

Insurers considered good claims management requires staff to have clear objectives and functions, and the skills and financial and operational capacity to meet them. Systems and processes need to be flexible enough to adapt to the changing circumstances which are characteristic of this industry. They noted that knowledge management and data systems have a key role in supporting claims teams' activities.

Under-deductible claims

Insurers vary in the level of detail they require about under-deductible claims. As noted in chapter 2, management of smaller claims has increasingly become the responsibility of insureds, as levels of deductibles have risen in recent years. While some insureds handle such claims themselves (one said they found outsourcing to be prohibitively expensive), others have appointed their insurer, a claims management firm or a broker to handle these claims. Some insureds choose to have a high deductible, in part to keep control over the way smaller claims are handled and the associated reputational effects with their customers.

Some insurers have concerns about any large-scale transfer of under-deductible claims management to insureds, preferring to maintain a degree of control over all claims and be advised about all incidents. Other insurers were comfortable with allowing the insured party to handle under-deductible claims as long as all incidents were reported to them.

Choosing the key features of the claims management process

The need to be proactive

Insurers commonly said that a key feature of their claims management processes was their 'proactive' approach. In essence, this involves taking control of a claim and moving it quickly towards a settlement. One said its approach is to determine liability and 'try to settle as soon as possible at a figure everyone can live with'.

However, some non-insurer organisations disputed that all insurers are proactive. One commented that 'in the conventional claims process, insurers are like ostriches — they resist claims and are prepared to gamble'. Another thought that some insurers seem to interpret being proactive as simply taking the lead in generating correspondence and seeking information.

Nevertheless, being proactive ('being on the front foot') is widely regarded as best practice by public liability insurers. It is something they claim to be continually

striving for and arises from the judgment that being proactive makes cost-effective outcomes much more likely. It is also consistent with the view expressed by all insurers that costs rise markedly the longer a claim remains outstanding. That said, the aim of claims management is to fulfil insurers' obligations in a cost-effective way and, in some instances, this may require a lengthy process and resort to legal processes to reach settlement.

A proactive approach that combines the efforts of the insurer and the insured party (or industry representatives) may also contribute to cost effectiveness. In its recent report, the Senate noted that the Australian Consulting Surveyors Insurance Society had:

> … established a series of panels which work closely with insurers to examine claims as soon as they are lodged … this approach in dealing with claims, coupled with its pro-active role in risk management, has resulted in members' insurance premiums being contained to acceptable levels … the general level of increase in premiums would be in the order of 30 to 40 per cent. Those surveyors with higher premium increases would be as a result of 'very bad claims record'. (Senate 2002c, p. 67)

At December 2002, the Insurance Council of Australia was revising its Code of Practice. The Code is to cover all classes of insurance written by its members and is to make a strong statement about claims service. As part of the process, a draft consultative document was to be released inviting wide community consultation and response.

A greater role in injury management?

Some insurers expressed interest in playing a greater role in injury management as a way of being more proactive in settling bodily injury claims. This might encompass appointing a case manager to assess rehabilitation options or suggesting appropriate specialists or therapists. They believed that by taking a strong role in injury management they might:

- reduce claims costs by speeding the recovery of the injured party and perhaps getting them back to work sooner;
- improve the accuracy of reserves by better predicting likely payouts; and
- better predict when the injury would stabilise and when serious negotiation of the settlement 'quantum' could begin.

However, they acknowledged that injury management is not easy to implement in a common law environment where the extent of liability is an issue. The Institute of Actuaries said:

> One of the best ways of minimising claim costs is to work closely with the injured person to ensure the best possible treatment and rehabilitation … The adversarial system, with its emphasis on monetary compensation, places a premium on maximising the appearance of injury and is diametrically opposed to [this]. (2002, p. 12)

Insurers also said that their ability to play a role in injury management is hindered by delays in receiving claims from injured parties or their lawyers. One noted that it is 'hard to focus on the quick recovery of the injured party when the claims come in years after the incident'. A UK report also found the lack of timely notification by a claimant's legal representatives to be a major impediment to a more injury focused approach (ABI & TUC 2002, p. 20). The extent to which the delay is due to claimants waiting for their injury to stabilise, or whether they are tactical, is unclear:

> The UK's tort culture has built a lack of trust between parties that creates delays and so reduces the chances of an injured person being referred for treatment at an early stage. That said there are many examples of liability (third party) insurers providing for rehabilitation within their products. (ABI & TUC 2002, p. 16)

The report gave the example of AIG Europe, one of the United Kingdom's largest commercial insurers, which formed a specialist company, staffed by qualified medical practitioners, to assess bodily injury cases. The company gathers medical evidence, establishes contact with the injured party and provides a case manager. It aims to facilitate a return to work, and it is not concerned with questions of liability. AIG Europe said this practice has allowed earlier settlements and more accurate reserving. Claims handling costs have remained largely unchanged, but less is being spent on litigation and more on medical expenses. The size of settlements has also fallen as injured parties usually return to work earlier.

The report added that, while the business case to support a definitive statement on the cost effectiveness of rehabilitation for insurers in the United Kingdom has yet to be made:

> … active participation in the rehabilitation process by insurers in other countries has been shown to provide them with a mechanism to control claim costs more effectively. (ABI & TUC 2002, p. 15)

Reflecting their belief that rehabilitation ought to be a key feature of the claims management process, the Association of British Insurers and the International Underwriting Association of London recently developed a *Code of Best Practice on Rehabilitation, Early Intervention and Medical Treatment* to:

> … encourage insurers and personal injury lawyers to consider the rehabilitation needs of claimants as soon as possible after an accident. The traditional approach of waiting until after the legal process had been exhausted usually meant it was too late for rehabilitation to be effective, compared with an early, optimal intervention. (ABI & TUC 2002, p. 16)

Early reporting of injury, and speedier assessment of medical and rehabilitation needs, are at the core of the Code. It sets out the duties of the claimant's solicitor and the insurer, and details best practice for the assessment and reporting.

Were Australian insurers to take a more injury-focused approach, they would be able to draw on the skills of the CTP and workers' compensation staff they employ. However, one insurer noted that greater involvement in injury management would require 'a change of mind-set' for liability staff, and would have important implications for staff selection processes, in-house training and supervision regimes.

A shift towards injury management may also move insurers closer to the claims management style of self insurers. For example, self insurers are more inclined to contact an injured party following an incident report and pay early treatment costs, without necessarily admitting liability, before the case is 'settled'. A self insurer's style of claims management is driven in part by a desire to maintain a good reputation, largely because self insurers' claims are often from their customers.

4.2 Operational approaches to claims management

Once the strategic approach to claims management is determined, there is a need to design operational processes. The following section looks at the design and functioning of insurers' claims teams and the processes they follow.

Designing in-house claims teams

In-house claims teams are typically small, but caseloads per staff member differ significantly across insurers, varying between 100–150 and 250–300 current files per claims officer. Caseloads as high as 450–500 were reported in 1999 (Kumar 1999, p. 31). Current industry practice is considered to be about 200–250 files per person, although this is being reviewed because of the tradeoff between thoroughness and speed. Those preferring smaller caseloads said they want more emphasis on quality claims management and said that, despite the consequent need for higher staff numbers, the ability to devote more attention to each claim saves money in the long run.

However, while lower caseloads may appear to be more conducive to proactive management of claims, it is difficult to draw conclusions on the basis of caseload data. Differences in patterns of claims contribute to variations in caseloads and there can be huge differences in the size, complexity and uniqueness of individual claims. Differences in the allocation to claims management staff of other administrative

tasks, such as filing and claim payments, may also lead to variations in average caseloads across firms.

Claims are allocated to staff in a variety of ways. Some insurers follow a 'streaming' system whereby a claim is assessed for its type and complexity and then allocated to a staff member or a team with appropriate experience. Others spread claims around more randomly. The capacity for specialisation by team members varies.

There were mixed views on the merits of centralising claims staff in one location. Most have claims handling operations in only a few locations. Centralisation is seen as encouraging greater consistency and control of claims handling, and allowing more flexibility in staffing. However, others said that this was inappropriate in view of differing State legislation and court systems, and the need for local knowledge of, for example, medical experts. They felt it led to 'abandoning files to the lawyers'. Perhaps for such reasons, insurers with centralised claims staff still tended to have some jurisdictional specialisation among their staff.

It is not clear how well linked claims staff are to other parts of the business and, in particular, to the underwriters. One broker suggested that, while such communication was important, it was sometimes discouraged for fear that underwriters might be thought to be influencing decisions about particular claims. Nevertheless, most saw benefits in such interaction — 'underwriters need to know the consequences of what they write in policy documents, and claims staff need to understand what is covered and what isn't'.

Claims staff and skills development

While some judged that their claims staff had relatively high skill levels and that there was no skill shortage in the industry, others argued that they were, in general, under-skilled and under-paid. One broker commented that claims management in Australia was '… not a place for high flyers … (whereas) in London they are the stars'. A specialist claim firm had similar views, saying that claims staff were commonly not highly regarded in the industry. In its view, American companies paid claims staff appropriately, but this was not true of UK and Australian insurers. Other participants expressed concern that ongoing merger and acquisition activity had led to a lowering of morale and an exodus of experienced claims management staff.

Insurers acknowledged that, in the past, claims staff had much lower status than, for example, underwriters and marketing staff. But they said a hardening of the insurance market and a succession of losses had reinforced the view that efficient

management of claims was critical to their bottom line. They said that ongoing changes had been made over the past decade to improve the skills of the claims workforce and that claims management is now treated as a professional, rather than a clerical, role. It is now much more about 'managing' a claim, rather than just 'processing' it. However, due to the 'long tail' in public liability insurance, insurers expect that the benefits of these changes could take some years to feed into financial results.

Staff development typically consists of a combination of professional study and on-the-job learning, including by in-house training programs. One insurer noted that internal seminars by lawyers on the latest legal developments helped to shape its processes. Many staff have tertiary qualifications, usually in commerce or law, or specialised insurance or securities qualifications. But some said they are now looking to, for example, the health management field to attract new staff.

Views on the efficacy of in-house training were mixed. One insurer said its focus was on in-house training — 'coming up through the ranks'. Another found it achieved best results when it hired experienced insurance people. A third said that the main skills required were the ability to 'read, communicate and have common sense' (that is, attention to detail, communication skills and good judgment) and that other factors were secondary. (Other features of claims management staff that industry participants felt were important are listed in box 4.1.) It was widely agreed that the skills and attitude of staff were the key factors — 'even with a big effort in training, if the attitude is not right, you'll still get bad outcomes'.

Overall, insurers said that staff turnover in public liability claims management was lower than in other areas of insurance. Insurers also indicated that their salaries are now higher than for motor or property insurance claims staff. It is common for staff to move between insurance companies (a trend strengthened by movement of staff post-HIH). McCarthy and Trahair (1999) said that 'it is difficult to recruit and train staff and a common response seems to be … to cherry-pick from other insurers'. The Institute of Actuaries noted that staff turnover contributes to common practices across the industry, as staff transfer their working methods from one firm to another. However, another implication is that a claim spanning four or five years could have a number of different claims officers handling it at different times. This affects relationships with the claimant and has implications for claims management and review systems.

One insurer, judged by several participants to be a leader in claims management, attempts to engage quality staff with professional qualifications or wide experience. It described its staff development training as 'extensive' and noted that most staff visited an overseas office for training. It found that its heavy focus on staff selection and training, together with a policy of a low caseload per person, allows it to

provide high quality customer service to its clients and to reduce reliance on outside solicitors.

Box 4.1 **Best and bad practice for claims managers**

From their experience in dealing with external legal representatives, industry participants suggested a number of features of claims management that they considered to be 'best practice' and 'bad practice'. They considered that good claims managers:

- accurately assessed liability at the time the claim was made;
- realistically assessed quantum;
- made reasonable attempts at settlement;
- responded promptly to correspondence;
- assisted with rehabilitation in cases where liability was clear (for example, providing financial resources for medical care prior to settlement if this was required);
- settled quickly or promptly listed the claim for trial; and
- maintained good relationships with other claims management staff, including being available to give advice and instructions.

On the other hand, 'bad' claims managers:

- unduly focused on requests for particulars when liability was clear;
- did not respond to formulated claims, with the plaintiff solicitor having to chase up responses;
- made unrealistic settlement offers;
- failed to follow procedures correctly or were unnecessarily slow in providing information;
- did not respond to correspondence;
- took issue with a claim without any compromise or discussion;
- made offers of settlement only after the matter was listed for hearing and all parties were at court for the hearing;
- failed to promptly respond to offers to settle; and
- denied liability, prevaricated until proceedings were issued and only then took part in meaningful negotiations.

Matching a claim with the 'right' staff member is considered very important by many claims managers. One insurer noted that, for both complex and simple claims, there is a need for experienced staff to undertake suitable investigation and push the claim forward at an appropriate pace. Rose & Riley suggested that claims should be

'streamed' and allocated to staff according to the size of the risk and the characteristics of the claim. They said:

> … the sort of individual who would most effectively deal with a claimant before their condition has even stabilised — applying rehabilitative support, for example — would be very different to the style of person who would, say, negotiate a commutation of benefits … the most effective way [to risk stream] is on the basis of the claimant's condition, pro-activity of the treatment regime and the passage of time since the onset of the condition. Combined, we believe these features represent the most accurate proxy for cost potential. Assessors should be allocated on the basis of their skills to manage that risk. (2000, p. 7)

The claims management process

As noted earlier, insurers emphasised that, in public liability, most cases are unique. Different injuries, different circumstances and different policy wordings with respect to conditions and exclusions, mean that standard processes usually need to be 'tweaked' on a case-by-case basis.[2] Processes also differ by jurisdiction, partly in response to legislative differences and legal cultures. Insurers said that a best practice process for one claim might not be a best practice process for another and considered that flexibility was important. All said that it was difficult to say what was meant by 'international best practice' in public liability claims management and considered that there was no 'world class benchmark'.

Some insurers said that they did not have claims handling manuals that set out the claims process in detail. Instead, they issued occasional guidelines to staff, and relied on in-house training and the experience of staff. One major reinsurer noted that having a claims manual was not a guarantee that procedures were being followed and that some insurers successfully implemented their claims management philosophy and style via key performance indicators for their staff. But in its view, there were advantages in having a claims manual.

To illustrate the general path a claim can take, and to show the range of scenarios insurers deal with, the flowcharts in figures 4.1 and 4.2 show the progress of a claim from incident to settlement via four different notification channels:

- an incident report from the insured party (figure 4.1);
- a letter directly from a claimant (figure 4.1);
- a letter from a claimant's solicitor (figure 4.2); and
- a writ/Statement of Claim issued by a court (figure 4.2).

[2] One major insurer noted that this uniqueness also creates higher costs in writing public liability policies. It estimated that writing a more complex policy could take one day of a senior manager's time.

Figure 4.1 **The claims management process 1**

From incident reports and claimant letters

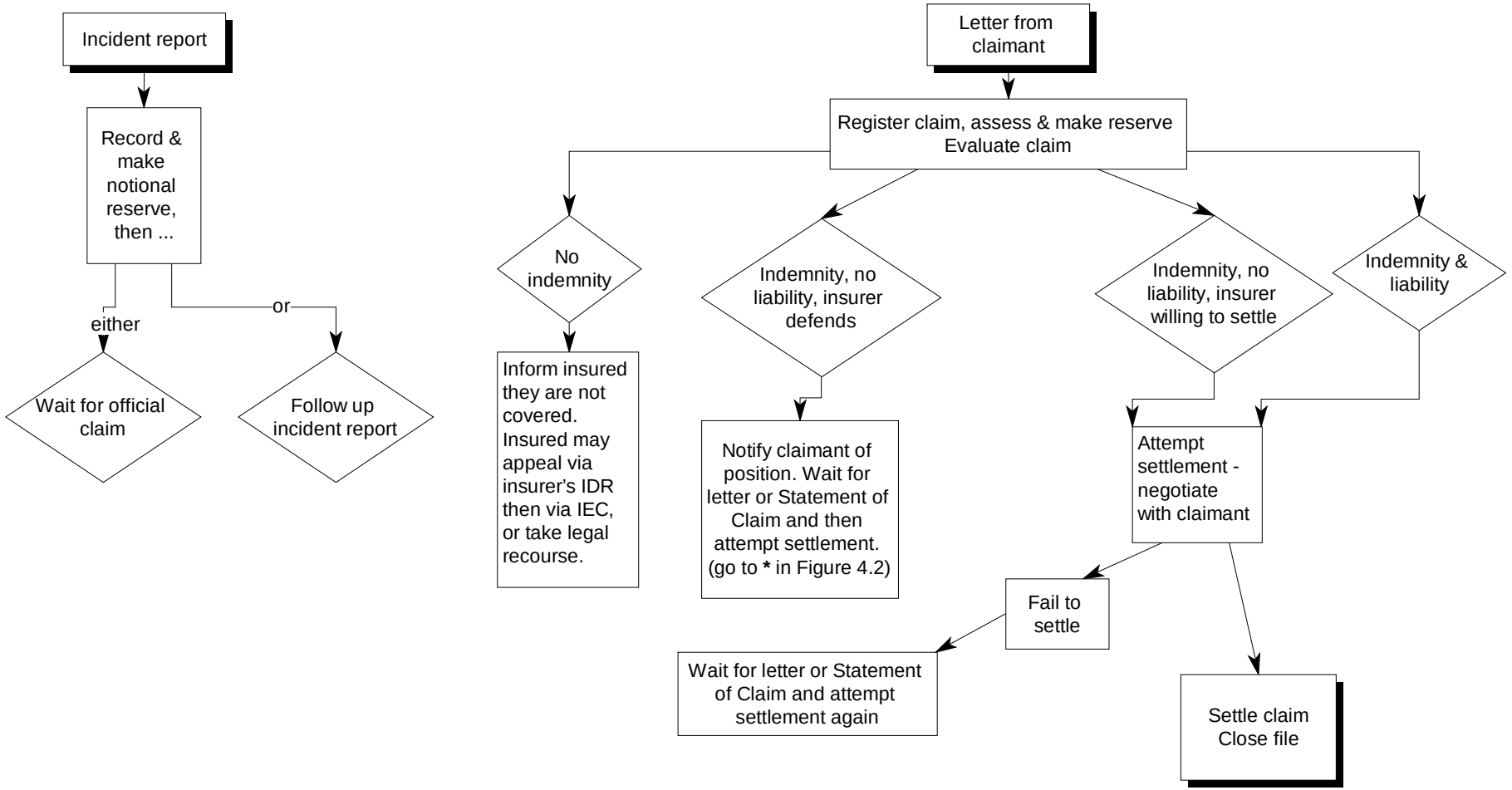
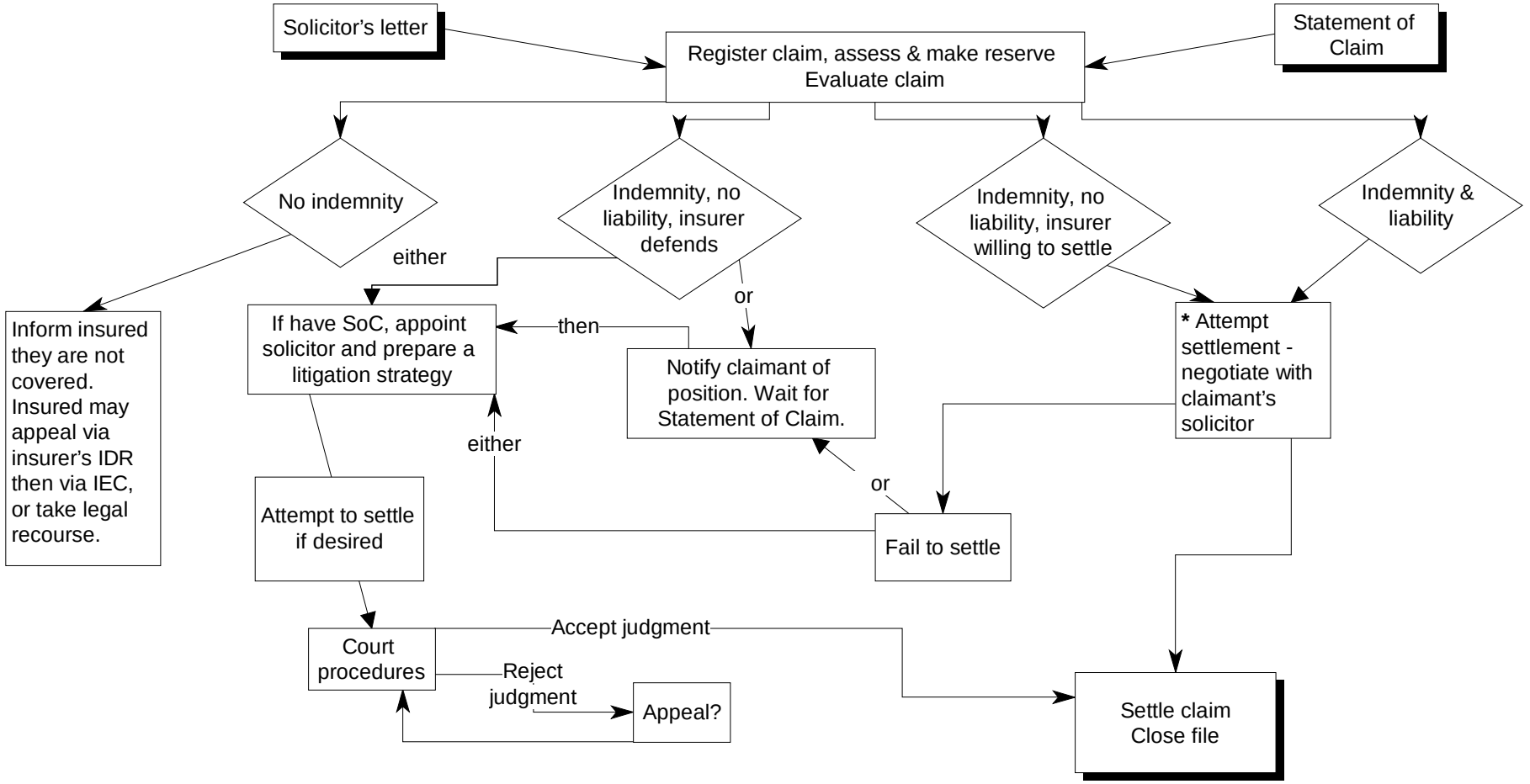


Figure 4.2 **The claims management process 2**

From claimant solicitor letters and Statements of Claim



The flowcharts highlight that claims handling can be a complex process. There are many decisions and judgments to be made, from setting a reserve and deciding on a strategy, to negotiating with clients and preparing for litigation.

In managing claims, insurers stressed the importance of accurately performing the initial steps of:

- assessing claims for indemnity and liability; and
- setting reserves.

This enables insurers to develop cost-effective claims strategies and reduce 'claims leakage' due to, for example, paying out on claims not covered by the policy (box 4.2). Claims leakage is thought to account for 5 to 10 per cent of claims costs. Depending on how leakage is defined, a leakage of 5 per cent would be seen as a good outcome.

Box 4.2 **Claims leakage**

'Claims leakage' is a term used in the insurance industry to refer to situations where the costs of a claim exceed some notion of 'efficient costs'. In discussing leakage, it is useful to draw a distinction between 'hard' and 'soft' leakage.

- *Hard leakage* includes paying claims for incidents not covered under the policy and failing to make appropriate recoveries (for example, from reinsurers).
- *Soft leakage* includes finding that some spending on investigation had been unnecessary and paying more to settle a claim than was apparently necessary.

Insurers agree that hard leakage is undesirable, results from poor claims management practices and should be reduced. However, it is more difficult to say this about soft leakage, which stems from the commercial realities that insurers face. For example, if a claims manager judges it is worth paying an 'above average' amount to a claimant to achieve an early settlement and avoid a potentially expensive escalation of the claim, it is not clear that should be labelled 'leakage'. This is a commercial decision for the insurer. Soft leakage stems from the inherent subjectivity of assessing claims — as one insurer commented, 'you can't take the human factor out of claims management'. Despite this, claims leakage studies are a useful tool to highlight possibilities for improvement in processes and to identify areas where better processes or additional staff training may be required.

Insurers noted that legal fees and court costs and procedures directly influenced their strategies for handling a claim. One commented, 'you calculate court costs to see how far you will go in negotiating'. In view of this, insurers used a wide variety of methods to attempt to settle claims before they reached a court hearing (box 4.3 describes the use of informal settlement conferences). Insurers also felt that the

nature of their working relationships with plaintiff solicitors influenced their approach — they typically had better rapport with some than with others. Plaintiff lawyers made similar comments about insurers. Clearly, when there is legal involvement, productive working relationships between the opposing parties are important to cost-effective claims management.

Box 4.3 **Settlement conferences**

Informal settlement conferences are one method some insurers have used to try to reduce the number of outstanding claims on their files. It involves an insurer with a number of outstanding claims with a particular plaintiff lawyer, arranging a meeting to review them all and trying to settle as many as possible at that time. Settlement conferences may also be held if there are a large number of claims outstanding in a particular regional location. Again, the insurer would arrange a venue in that location and attempt to settle as many claims as possible at the one time.

However, the results to date from the use of settlement conferences are mixed. One insurer has had success with settlement conferences and claimed that they are valuable in settling a large number of smaller claims quickly. However, another told the Commission that it had invited 23 plaintiff lawyers to attend settlement conferences but had garnered no responses. The insurer is still keen, but is uncertain whether further attempts will be any more successful than the last.

Insurers said that they generally prefer to handle claims in-house, with minimal resort to investigators and other external consultants. Assessing whether outside expertise is required is a matter for claims staff, drawing on the experience of other staff handling similar cases.

The point at which insurers engage a solicitor for legal advice differs from case to case. For complex claims, insurers said they often appoint a solicitor early in the process to give advice, regardless of whether a Statement of Claim had been received. In other cases, claim managers themselves negotiate with the claimant or claimant's solicitor, relying on internal sources for legal advice.

Insurers noted that the time taken and the costs of getting a claim through the processes depicted in figures 4.1 and 4.2 can vary dramatically. Various steps can turn into 'break-points' in the claims management process, where costs and time blow out. For example:

- The nature of the incident is a good predictor of time and cost. Property damage claims can typically be finalised within six months of being lodged, with a small claim perhaps taking only three months. However, a personal injury claim may take three to four years to settle, with more complex injuries and claims involving minors often taking much longer. Personal injury cases also tend to

have multiple defendants and, therefore, multiple insurers are involved — this can also increase the time taken to finalise a claim, as insurers are usually not willing to settle until the issue of apportionment between insurers is resolved. This can lead to cross-litigation between insurers as they seek recoveries. In terms of costs, the average size of a property damage claim is about one-fifth that of a personal injury claim (Trowbridge 2002a, p. 12).

- The manner in which a claim is notified often gives a sense of the potential costs of that claim. A major insurer said that it increased reserves significantly if notification came via a solicitor's letter rather than a claimant's letter. Also, if the notification came via a Statement of Claim, then the reserves made would be much bigger again. This is a clear indication of the significance of legal costs and proceedings.
- As noted earlier, the time from an incident to a notification of a claim can be lengthy. There was little agreement on the reasons for delays — while most agreed that the need for an injury to stabilise can delay notification, some insurers complained that plaintiff lawyers have an incentive to 'sit on' claims to strategically hinder their ability to test the veracity of claims. However, plaintiff lawyers argued that 'no win, no fee' arrangements with their clients provide them with an incentive to settle claims quickly and that delays in the process are due to insurers not responding quickly to claims. Some insurers also felt that there could be valid reasons for insured parties not notifying them of incidents immediately, particularly in domestic claims where, say, an argument between previously friendly neighbours could lead to an earlier incident turning into a claim.

Insurers try to encourage the early notification of claims by sometimes placing incentives on the insured party to notify them of any known incidents that may lead to a claim, so that reserves can be set and appropriate action initiated. They considered that faster claims notification would be one of the most important improvements that could be made. Some see recent reforms in Queensland, where time limits have been set for claims notification, as one way of achieving this.

FINDING 4.1

Fundamental to public liability claims management is the need to establish liability and the quantum of damages within an adversarial common law system. This has a major influence on the costs and time taken to handle public liability claims in Australia.

FINDING 4.2

Claims management practices are driven by commercial incentives for insurers to meet their contractual obligations to their customers in a cost-effective manner. The broad steps involved in managing claims are fairly common across the industry. Differences arise because, for example, the portfolios of public liability risks underwritten by insurers differ and require different claims handling processes.

FINDING 4.3

There is no single best practice for claims management — no 'one size fits all'. Management of claims for 'slips and trips', for example, can require significantly different approaches to claims for property damage or catastrophic bodily injury. Claims management needs to be tailored to deliver cost-effective outcomes in the light of the specific circumstances of each claim.

Learning from overseas practice

The Commission was told that the steps involved in managing public liability claims were broadly similar across common law countries. On a number of occasions it was also told that claims management was 'commonsense, not rocket science' and that, once the strategy and overall approach has been determined, the operational steps should follow fairly automatically.

Insurers already make use of international linkages to transfer innovations and best practice techniques to Australia:

- At a broad level, insurers monitor developments around the world to assess, for example, the implications for them of major insurance events or advances.
- Most are able to compare their processes with others by gathering information at meetings, conferences and the like. International conferences, in particular, are seen as an effective way of sharing information and ideas with claims managers in other countries, and in other fields of liability insurance.
- Those firms with offshore parents are able to tap directly into the experiences of offshore companies in their own corporate group. For example, one has a formal 'knowledge exchange' program within its global group. Several routinely share information and have staff placements across countries.
- Reinsurance arrangements also provide linkages into the international market. Reinsurers undertake regular 'client reviews' of insurance firms that take out reinsurance with them. These include in-depth investigation of their claims management practices and procedures, encompassing all the stages of a claim,

and of staff performance. The scope of these reviews, and their impact on claims management practices, has increased recently in the light of difficulties in both insurance and reinsurance markets. Some reinsurers also routinely supply insurers with data or briefings on insurance matters arising elsewhere and their implications for Australia.

In addition, insurers are able to employ the services of specialist insurance consultants, some of which have international affiliations. Under these influences, public liability insurers in the Australian market are able to learn of new developments and have the scope to take on board new practices to improve the management of claims from their public liability 'book'. In doing so, insurers need to take account of any jurisdictional differences that may require new practices to be modified for use in Australia (see box **Error! Not a valid link.**).

FINDING 4.4

The international links which insurers have through ownership and reinsurance arrangements, for example, encourage dissemination of ideas and techniques with respect to best practice in claims management. Exchanges of staff, international conferences and the like further encourage this.

4.3 Feedback loops

A number of feedback loops may be added to the claims management processes detailed in figures 4.1 and 4.2. For instance, insurers may undertake *performance reviews* of claims management staff, or *review claims processes* to see whether improvements can be made. Similarly, insurers may undertake *risk reviews*, where information on claims is used to evaluate the insurer's risk profile and to feed back to the insured party (via the underwriting staff) to assist in their risk management activities.

Reviewing performance

Insurers appear to have relatively similar approaches to performance reviews. In line with their general goal of settling claims quickly at the lowest possible cost, reviews are mainly focused on actively managing claims and checking the accuracy of reserves. Typical procedures include:

- weekly checks of claims 'to do' lists;
- monthly 'claims status' reports based on a sample of claims;
- alerts for 'inactive' claims;

Box 4.4 **International comparisons and claims management**

In many cases, it is not possible to take international practices and implement them 'as is'. Claims managers wishing to use new practices from overseas will often need to make some adjustments to these practices to take account of the differences between countries. For example, among common law countries with similar legal and regulatory systems, there are important differences in statutory requirements and legal rules and procedures that affect the incentives faced by plaintiffs and insurers. They also influence approaches to claims management.

- There are statutory differences on such matters as caps on payouts, the size of legal fees in specified circumstances and the situations where strict liability must apply. These also vary within countries (for example, there are significant differences between American states and between Canadian provinces).
- Community concerns about liability insurance in the United States of America and Canada in the 1980s led to changes in legal and regulatory regimes for liability cases. However, some recent or proposed changes (such as class action reforms and caps on damages) are being reviewed and debate about the tort liability system continues (CEA 2002, British Columbia 2002).
- In most European countries, civil litigation generally follows the 'English rule', whereby the loser pays the winner's legal fees. In contrast, the 'American rule', which requires each side to pay its own legal fees, still applies to most civil litigation in that country. This influences the incentives to settle or to litigate.
- In contrast to Australia, Canada and the United Kingdom, jury trials are common in American liability cases. Its legal system also allows for the awarding of punitive damages.
- Attitudes towards litigation differ across countries, while advertising by lawyers and the availability of 'no win, no fee' legal services varies considerably between jurisdictions.
- Access to alternative dispute resolution procedures also varies. In the United Kingdom, for example, the Woolf reforms discourage litigation and encourage the use of alternative dispute resolution and sharing of information. However, if settlement is not achievable, there are requirements to ensure the parties are prepared to comply with court timetables and procedures.

- six-monthly claim reviews;
- claims leakage studies; and
- reviews of case reserves, checking for ongoing accuracy and investigating any large movements.

In many cases, staff assessments and bonuses are based on their performance in settling claims (eg initiative taken in settlement, time taken and costs), reserving and following procedures. The duration of a claim is a key performance indicator

for many insurers, as is overall claims cost. Most performance comparisons are against similar claims in previous years, although some insurers set targets or employ a sense of 'industry averages'.

Basic procedures for reviewing performance appeared to be fairly consistent across the industry. Claims leakage studies were highlighted as particularly important by specialist claims management firms, which noted that badly handled small claims can cause significant leakage in costs (box 4.2). In their view, best practice claims management must be implemented to minimise problems such as unsatisfactory progressing of a claim, insufficient effort to detect fraud and ineffective working arrangements with service providers.

Regular, accurate assessments of case reserves were regarded as a vital component of performance assessment and crucial to the assessment of claims reserves. Because of their importance, McCarthy argued that there should be 'independent (ie external) review of the adequacy of case estimates by a competent technical claims expert' (2001, p. 43).

From its meetings with other industry participants, the Commission gathered that the key performance indicators used by insurers are also fairly standard in the industry. For example:

- a specialist claims firm used a number of indicators, including goals of receiving incident reports in a set time, averaging a particular payout per claim, litigating less than a certain percentage of claims, and maintaining reasonable loss development;
- several participants (including reinsurers) suggested that criteria for assessing performance should include consistency of claims handling, adherence to claims manuals, standard of claim estimation, amount of claims leakage and the extent to which claims staff were proactive (see box 4.5); and
- others said that performance reviews should encompass indemnity assessment, liability assessment, reserving, strategy and tactics towards quantum, consistency, negotiations, use of investigators, claims leakage and interaction with underwriters and marketing staff.

Reviewing processes

Most reviews of internal processes appear to occur on an occasional or ad hoc basis. But some insurers are embarking on more substantive benchmarking exercises. For example, one is undertaking a five-year project looking at 'what is world class' in the broader general insurance business, while another is looking to review public liability claims processes against other lines of insurance within its business.

Box 4.5 **Reinsurers and claims management**

It is now common for reinsurers to undertake reviews of the claims management practices of the insurers they deal with. This enables reinsurers to check that insurers are handling claims appropriately and that the cost of their claims are not inflated.

Typically, reinsurers review a selection of claims files and, on the basis of their findings, present a list of recommendations to the insurer. While reinsurance is not usually conditional on the actioning of these recommendations, follow-up action (or a lack of it) could influence the cost of reinsurance.

The reviews look at the following types of issues:

- Is claims management following the philosophy and style set out in claims manuals or other guidelines?
- Are there appropriate techniques for setting case reserves? Are there time standards and adequacy checks?
- Is case evaluation practical and timely?
- Are staff adequately skilled for their jobs?
- Is the system of supervision adequate?
- Are investigations prompt, complete and undertaken by the appropriate staff? Are they proactive?
- Is there prompt and complete reporting and updating?
- Is fraud handled appropriately? Are exclusions applied properly?
- Is claims analysis and gathering of statistics adequate?

Given the global reach of many of the reinsurers operating in Australia, these reviews are also an opportunity for reinsurers to compare the processes of Australian insurers against similar firms overseas.

Source: Commission discussions with reinsurers.

Local insurers considered that the nature of the legal environment in which public liability claims are assessed necessarily leads to a particular way of operating. They thought that, overall, when this was taken into account, the claims management processes used by Australian insurers are as good as those observed in other countries. Several participants, including some with direct international experience, believed that while processes were fairly similar in Australia, the United Kingdom and the United States of America, they were not the same. The variations were attributable to, for example, differences in legal and regulatory environments.

However, while the information available to the Commission is not wide-ranging, it is likely that there are ways to obtain more value from such comparisons:

- In principle, insurers may be able to benchmark their processes against those of other players in the industry. There are a number of insurers with overseas links operating in the local market, as well as specialist claims management firms. However, in practice, firms may be unwilling to share information, particularly if it pertains to an area of competitive advantage. Processes in different firms may also have a strong element of 'tacit knowledge', which is less accessible to firms collecting information (Fronsko 1999).
- There is also scope for insurers to look at the claims management practices in other insurance classes. For example, in managing disability claims arising under life insurance policies, General Cologne Re uses a large web-based database on 'disability durations', combining actuarial data and medical expertise, to source more detailed information on injuries and the typical duration till recovery (O'Sullivan 2002). This information is used to provide a more objective assessment of the claim, set expectations about 'return to work' times and provide more information about treatment and recovery. This sort of information could also be useful in public liability claims management.
- The production or review of claims handling manuals or written guidelines can be a valuable impetus for analysing the claims process and identifying areas where practices can be improved. The simple act of recording current practices can also highlight whether claims management processes are aligned with the insurer's overall strategy. Written guidelines, in the form of manuals, process guides or performance indicators, may also be useful for staff as expectations and required standards of service are clearly defined.

Insurers suggested that turbulence in the industry over the past few years has taken time and energy away from the task of enhancing processes. Several participants noted that merger activity (and the absorption of ex-HIH business) has diverted the insurance industry's focus away from longer-term operational improvements towards more immediate concerns, such as integrating new staff and systems into current structures. A more settled environment should allow insurers more scope to focus on refining their processes.

Reviewing risk

As noted earlier, another valuable feedback loop to add to the claims management process is risk assessment, where information on claims is used by the insurer to evaluate its own risk profile and to assist policyholders in their risk management activities (via feedback from the underwriting staff).

In the current 'hard market', insurers have been reviewing the types of financial risks they are willing to underwrite and the pricing of them. This is evident from the

changing premiums (mostly increasing) and coverage available in the market. Some said they were focusing on smaller risks and moving away from 'frequency accounts' such as shopping malls. On the other hand, others are moving into this area.

However, it is unclear whether this action is a result of a normal cycle of review and interaction between claims staff and underwriting staff, or a more general reaction to the realisation of losses in the market. Concerns were expressed several years ago, that:

> … industry members, with some notable exceptions, do not yet operate a disciplined and consistent control cycle. As a result, claims provisions are established with no systematic feedback to rate setting and other aspects of underwriting practices. Moreover, where insurers do have a feedback mechanism, a fear of losing market share often stops them from implementing higher rates or firmer practice. Regardless of why there is a lack of feedback, it is profit that bears the brunt of any missing link in the control cycle and, needless to say, a lack of systematic consistency between premium setting and claims provisioning has the capacity to be a general insurer's Achilles heel. (Jenkins 1998, p. 57)

Moreover, some insurers do not take a major part in the policyholder's process of risk management. While they might advise that 'slips and trips' have been on the increase, they do not systematically feed claims data back to the insured to help reduce risk. However, some do, and this can lead to better control of potential liability for the insurer, and reduced risks (and lower premiums) for the policyholder.

Specialist claims firms and brokers also said they visit the policyholder's premises and make detailed suggestions about how to lessen the risk of a claim. Specialist firms considered reducing the risk of claims, as well as handling those claims that do emerge, was 'core business' and part of their competitive advantage. For those that self insure, reducing risk impacts directly on their bottom line — fewer injuries equal less cost. Some self insurers with multiple sites of operation place this financial incentive directly onto the individual sites to reinforce their risk management policies.

Towards best practice

As part of its 2002 reforms, APRA now requires insurers to produce a Risk Management Strategy that:

> … identifies the insurer's broad risk management and control systems (including at a minimum the systems in place to address balance sheet and market risk, credit risk, operation risks and risks arising out of reinsurance arrangements). (APRA 2002e)

For claims management, APRA's role is to ensure that there are no weaknesses in the claims management process that may expose an insurer to the risk of unexpected losses that could jeopardise its financial viability. APRA's expectations are that:

> … at a minimum, the risk management system for claims management must consist of policies and procedures including:
>
> - clearly defined and appropriate levels of delegations of authority;
> - claim settlement procedures, including claim determination and investigation procedures and the criteria for accepting or rejecting claims;
> - loss estimation procedures (including estimated reinsurance recoveries); and
> - methods for monitoring compliance with claims management processes and procedures, such as: internal audit; peer review of claims paid; and assessment of brokers' procedures and systems to ensure the quality of information provided to the insurer is of a suitable standard. (APRA 2002g)

While not explicitly specifying regular feedback from claims staff to underwriters, it is clear that loss estimation and audit of claims, for example, provide vital information that may be used by underwriters in their work to aid in reducing the risk of unexpected losses.

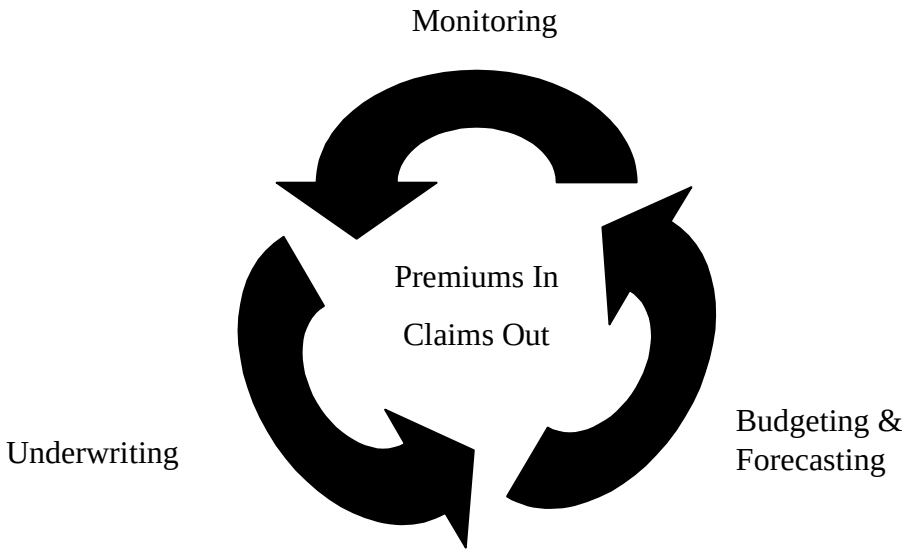
In implementing a review of risk, a formal 'control cycle' is valuable, as it imposes systematic feedback loops from claims staff to underwriting staff. In a control cycle, the insurer, in essence, gathers data, makes assumptions, sets premiums and capital requirements using those assumptions, analyses its emerging experience against those assumptions and, if necessary, makes revisions (Jenkins 1998, p. 56). An example is provided by McCarthy and Trahair (1999), who set out their view of a robust actuarial control cycle that can highlight pricing and reserving risks (see box 4.6). Their cycle also contains elements of performance and process review.

Good data are required to support a control cycle. Martin (2002) noted the need for data to be accurate and robust so that claims estimates are reliable and timely, claims trends can be tracked, and exposure to various incidents can be predicted. Data issues, including adequacy, are discussed in the next section.

At a more specific level, a technique known as 'triangulation', conducted on a product line basis, is important for monitoring the development of losses. The key task is to estimate claims that have been 'incurred but not reported' (IBNR) so that insurers can plan their finances and set premiums accordingly. Triangulation also checks that reserves for reported claims are adequate (as measured by IBNER — 'incurred but not enough reported'). Analysis by product line yields information about whether individual products are priced correctly, while triangulation on an aggregate basis (for example, for public liability, CTP and workers' compensation together) will indicate whether reserves are adequate in aggregate.

Box 4.6 **The control cycle**

McCarthy and Trahair (1999, p. 37) stated that a 'control cycle sets out a framework for the management of insurance products'. They presented the cycle diagrammatically as:



Each element of the cycle feeds into the next, in a continuous cycle of analysis and review of the insurance process.

In the underwriting stage, McCarthy and Trahair noted that the pricing process 'requires cooperation among a diverse group of people, including product managers, underwriters, actuaries, lawyers, marketers/business development managers and ultimately senior management'. They described the features of the pricing process as incorporating: assessment and quantification of risk; determination of capital at risk and reinsurance requirements; setting of average premiums; and setting of premium relativities. They believed actuarial involvement in pricing was desirable.

The budgeting and forecasting stage comprises business planning (in particular, setting strategies for products), product forecasts, financial budgets and overall forecasting of business.

The monitoring stage includes monitoring of: the external environment (eg precedent setting court cases, legislative changes, community attitudes); competitors, particularly any price changes; underwriting and claims compliance (to ensure consistent processes are adhered to, leakage is reduced and training needs are identified); and financial data, not only external information such as economic forecasts but also, crucially, portfolio performance against expectations.

McCarthy and Trahair (1999, p. 43) saw implementation of a control cycle such as this as '… the fundamental antidote to irrational pricing and underwriting … management should be able to make decisions with their eyes open'.

4.4 Data and technology

> All roads lead to Rome — for insurers, all the issues end up being about data. (McCarthy & Trahair 1999, p. 42)

As alluded to in the previous section, central to an insurer's ability to review its performance, processes and risk exposure is the quality of its data and information systems. Data are crucial to the insurance business — they enable firms to assess their insurance risk (that the actual value of premiums collected will be lower and claims liabilities will be greater than expected) and to monitor operational risks such as fraud and unsound policy drafting. Information can also be fed back to the insured party to aid in their risk management. With long-tail insurance, the information flows and data about the financial cost of public liabilities accepted can come some years after the policy is written or renewed. However, to monitor market trends, adjust premiums and alter underwritten risks it is important to collect, analyse and use such data. This section looks at how insurers manage their data and examines how the use of technology can assist in the claims management process.

Capture and use of data

Insurers keep data in individual files to help assess and settle each claim. Public liability claims files would typically contain some or all of the following: case estimates; particulars of the cases, investigators' reports and photographs; and all correspondence between the parties. This information helps staff assess claims for indemnity and liability, and to set realistic reserves for the claims. The data also assist in undertaking internal checking and auditing.

Several participants argued that data collection and analysis could add more value to the feedback stage of the claims management process than is currently the case. Trowbridge said:

> … it seems fair to conclude that the insurance industry in Australia has done a poor job in collecting and analysing data for public liability. (2002a, p. 40)

It noted that insurers have traditionally: not sought detailed information on risks and exposures; not coded and stored information accurately on their computer systems; and not analysed and used their information for premium rating purposes (2002a, p. 40). The Institute of Actuaries said:

> Because there is insufficient data, it is difficult for insurers and their actuaries to set appropriate rates for individual risks, and to set aside appropriate claim reserves. This has been a major contributor to recent inadequate premium rates, and increased the level of risk capital required to support Public Liability underwriting. (2002, p. 14)

It considered that, as better data became available, actuaries would be better able to advise on appropriate premium levels (2002, p. 12).

Insurers agreed that data analysis within firms could be improved. While it varies across insurers, not all useful information on paper files is available electronically and this hampers its use for other purposes. Some are currently working to improve their information technology systems to capture more data, although others do not appear to have immediate plans to change practices.

Several reasons were put forward to explain insurers' current claims data collection practices. These included:

- a proliferation of multiple systems within some companies, due to mergers and the introduction of new information technology systems. For example, one insurer noted that taking on HIH business meant taking on *five* data systems from HIH. The time involved in integrating these five systems with the two systems already in place in the firm due to an earlier merger, had proved immense. It also resulted in gaps in data series and difficulties in analysing data;
- the operation of pooled schemes, through brokers or other insurers, where an insurer takes a share of the pool. These schemes group claims and payouts together on a monthly or quarterly basis, so that an insurer simply writes a cheque for, say, the March quarter to cover its share of the claims settled in that period. As a result, an insurer does not have individual claims records and cannot relate particular risks back to individual policies;
- the difficulties posed by the variety in public liability policies. The diversity of risks, different levels of deductibles, a wide variety of exclusions and varying upper levels of indemnity make it harder to group data; and
- the short length of time some insurers have been underwriting public liability insurance, and the relative ease of entry and exit over time for individual insurers. Some insurers are only just starting to collect data, while others have a broken series of data, in part reflecting the time periods when they have withdrawn from public liability underwriting.

This suggests that, while there is potential for data analysis to be improved, public liability is a difficult and diverse area and data analysis may not reach the levels of sophistication that can be reached in other areas of insurance, such as workers' compensation. The Institute of Actuaries said, for example:

> One of the problems with public liability compared to, say, workers compensation and CTP is that within workers compensation and CTP there are pretty good proxies for what the measure of exposure should be. Within workers compensation, it is the number of employees you have or your payroll and it is relatively obvious that the risk varies by industry … In liability, there is no general proxy for what the measure of

> exposure should be. The diverse range of risks and the fact that different policies have completely different excess levels mean that it is very heterogeneous … There is very little similarity between the various risks and it makes it very difficult to price, even with data. (Senate 2002b, p. E282)

It also needs to be recognised that, first, improvements in data collection and analysis can involve firms in significant costs and, second, the magnitude of the costs and the associated benefits will differ between firms. Hence, judgments about how much time and expense should be committed to upgrading data will vary in accordance with insurers' assessments of the likely benefits and costs for their own operations.

Towards best practice

APRA's Prudential Standards on Liability Valuation (2002h) and Capital Adequacy (2002i) specify some minimum requirements for Australian insurers' data and information collection. In general, any firm writing long-tail insurance should be able to collate annual data on policies, claims, settlements and expenses, disaggregated across their different classes of business.

McCarthy (2001, p. 38) noted that, under APRA's new prudential standards involving the 'Approved Actuary', insurers must supply any data the actuary needs to perform their role, and that this will provide further pressure to improve data collection. APRA states:

> … the insurer must ensure that its Approved Actuary has access to all relevant data and people which the Approved Actuary reasonably believes is necessary to fulfil his/her obligations under the Act, Insurance Regulations 1974 and Prudential Standards. (2002j, para. 32)

McCarthy (2001, p. 45) felt that actuaries should therefore '… ensure they request all the relevant data and information and … work with insurer management to plan and take steps to obtain the data and information'.

Trowbridge noted that 'adequate underwriting, pricing and monitoring of public liability insurance requires a significant amount of complex data on exposure and claims' (2002a, p. 39). It said that it was necessary for insurers to have, for each risk they insured, a classification of the exposure to risk, quantification of the exposure and underwriting information describing the risk features, risk management processes and so on. This information would ideally cover five to ten years of history. Claims data should show the type of claim, the circumstances giving rise to the claim, payments and case estimates. This information is required at an individual policy level to enable assessment of an appropriate premium and policy wording, and also at an aggregate level to ensure overall premiums cover the risks

insured. The Institute of Actuaries (2002) presented a similar opinion on the type of data required by public liability insurers (see box 4.7).

Box 4.7 **Data requirements**

In its submission to the Public Liability forum, the Institute of Actuaries (2002, pp. 24–5) listed the main items it felt were required in a public liability database.

Exposure details — for each policy and, for diverse exposures, for each risk:

- type of risk and location;
- period of exposure;
- an objective measure of size of the exposure base (dependent on type, for example, turnover or payroll);
- selected underwriting criteria (dependent on type);
- premium charged, sum insured and excess (per claim, per event and aggregate); and
- premium adjustment basis (if any).

This information would be required for any sub-components of a policy with different details, for instance, if property damage coverage had a different policy limit. For highly standardised policies, such as the public liability component of house policies, aggregated details would be acceptable.

Claim details — for each claim/incident report within each event (and within each policy period for aggregate sum insured policies):

- link to policy (or copy of policy details);
- types of claim (physical damage/bodily injury/suffering);
- date of incident and date of incident report by insured to insurer;
- date of claim to insured and date of claim to insurer;
- date of settlement, type (verdict, arbitration etc) and date finalised;
- location of incident;
- jurisdiction (location, court/unlitigated);
- details of loss;
- details of payments, deductions and recoveries (other than reinsurance), including date, amount and type;
- details of incident costs not covered by policy, for example, costs under the insured's excess or over the policy limits; and
- estimate details and estimate history (totals only).

However, information collection has a cost — the depth of information actually collected will depend on the insurer's assessment of the worth of collecting it. As Trowbridge noted:

> For businesses where there are tens of thousands of policies for just a few hundred dollars premium, it is not economically viable to spend hundreds of dollars collecting and analysing data on the risk characteristics of each policy. (2002a, p. 40)

FINDING 4.5

Insurers generally have sufficient information to manage their own claims effectively. But better use of claims data could be made by some insurers for a range of other purposes, such as premium setting and risk management.

Use of technology

The application of information technology in public liability claims management is mainly evident in the use of electronic claims management systems such as electronic filing systems, online diaries and the like. The supporting electronic systems differ across insurers, but typically involve a diary and 'to-do list', and regular reports on claims status.

In contrast, insurers were somewhat sceptical about the current usefulness of, for example, on-line claims management. Some saw on-line claims reporting as useful for high frequency claims — and this is used by some specialist claims firms, such as Proclaim and Wyatt Gallagher Bassett — but not for others.

Differences in levels of computing capability may also be an issue. On-line settlement using a process of blind-bidding[3] is used overseas, and has shown benefits in terms of rapid settlement, better control and improved client experience. However, insurers believed it may be some time before the technology is widely used in Australia.

Towards best practice

Brokers involved in claims management argued that a sophisticated information technology system is a major asset, as it assists with reporting and risk management. They felt that insurers' systems tend to be inadequate for these purposes.

Specialist claims management firms also noted the importance of information technology. One firm commented that, as claims were its core business, it had the incentive to invest in high quality systems. It felt that insurers and self insurers were

[3] Blind bidding in on-line settlement is a process where the claimant submits their demand and a degree of compromise (say, 10 per cent) and the defendant submits their offer. Neither party knows what the other has submitted and settlement is reached when the defendant's offer meets the claimant's requirements. For examples, see http://www.venables.co.uk/settle.htm.

reluctant to spend money on this area of their business as they regarded it as 'non-core', and that insurers' systems were essentially set up for underwriting and calculating premiums, not systematically collecting detailed information on claims. Specialist claims management firms felt that capture of 'notification of claim' information was particularly valuable and that good information systems enabled them to be more proactive on receipt of these notifications.

As with many industries, technology has the potential to facilitate innovation and cost savings. To exploit this potential requires insurers to regularly review the availability and use of technology in their business and to take advantage of any opportunities that emerge which fit sensibly with their business strategy. As some insurers are presently struggling to cope with integrating multiple systems, it may be the case that consideration of such issues is not a current priority.

The National Office for the Information Economy (NOIE 2001) conducted a national electronic commerce (e-commerce) scoping study of the insurance industry (comprising the general, life and health insurance sectors). It considered that the insurance industry has been slow to take advantage of opportunities presented by this medium, with many processes still remaining paper-based. It saw opportunities for cost savings in its application to current business processes, such as claims management. The proposed initiatives which would have some relevance for public liability claims management are given in box 4.8.

Box 4.8 **Opportunities for e-commerce in the insurance industry**

The NOIE report indicated that automating the process of claims management would result in significant cost savings for the insurance industry. At a relatively simple level, enabling claim forms to be submitted online would reduce re-keying and error rates. There would also be efficiencies in enabling electronic communication between the many parties involved in the process of meeting a claim such as assessors, engineers, suppliers, tradespeople and retailers. Integration of processes and related systems could further reduce costs and improve customer service.

Other initiatives identified which could reduce administration costs were:

- online monitoring of claims;
- a central database of claims files, with access by all parties involved in the claim;
- electronic bill payment to suppliers of goods and services; and
- use of technology such as digital cameras and handheld computers by assessors to streamline the process of making inspections and writing their reports.

Source: NOIE (2001, pp. 18–19).

5 Legal costs and processes

Legal costs are a necessary part of a well-functioning public liability system based on the need to determine liability and damages under the common law tort of negligence. They represent a substantial and growing component of insurers' claims management costs. The involvement of lawyers in claims has increased with around 80 per cent of claims now being presented by solicitors (compared with half that level a decade ago). Litigation has been increasing but the proportion of claims settled by judgment has remained small and unchanged. Court-based case management systems, including alternative dispute resolution processes, can assist in the resolution of claims without the need to proceed to trial. There are some differences in legal costs due to differences in statute law, legal representation costs and court procedures across states and territories and these also impact on claims management costs. If current state and territory reviews of arrangements for public liability insurance lead to greater differences, claims management costs could rise further.

The nature and method of resolving public liability claims are such that legal advice, representation and disputation are often integral parts of the settlement process. Disputation about liability and the level of damages is primarily a matter to be settled at common law which, by its very nature, is adversarial.

While most settlements are unlikely to be made by a court, decisions by courts, the processes they dictate and the cost of using them establish the parameters within which negotiation between the parties takes place.

The following sections look at the importance of legal costs in managing claims, the impact of court processes and some differences between jurisdictions in terms of the application of tort law.

5.1 Legal costs

Claims management is heavily influenced by legal costs and processes, which may often determine how long a claim takes to reach settlement. But there is little public, industry-wide data on those costs. Judgments about the extent to which legal costs will be incurred are made by plaintiffs and insurers in their consideration of

individual claims. In addition, the legal culture within a jurisdiction may impact on the extent of these legal costs.

The main legal costs include:

- legal costs for plaintiff lawyers;
- the insurers' defendant lawyer costs;
- court representation costs (for barristers and the like) for both parties; and
- court charges (including pre-court case management), writ lodgment etc.

Plaintiff lawyers' costs are usually included as part of lump sum settlements paid to claimants and are generally not separately identifiable, even to the insurers who pay them. (For insurers, this avoids having to negotiate separately with plaintiff lawyers.)

Insurers' legal costs may include their internal legal costs and the cost of using external legal teams (in most cases, insurers outsource their legal representation). Again, while insurers know their own legal costs, this information is not collated for the industry as a whole.

Court-related costs depend heavily on the extent of representation required (senior barristers and Queen's Counsel may be used in major disputed cases). The costs are much higher in major centres such as Sydney than elsewhere. Anecdotal evidence suggests they account for a significant part of the cost differences across jurisdictions.

In relation to court lodgment fees, the Steering Committee for the Review of Commonwealth/State Service Provision found that, in 2000-01, New South Wales had the highest level of average fees collected per civil lodgment in the Supreme Court ($1538) and the District/County Courts ($682) (SCRCSSP 2002, p. 475). Average court fees collected per lodgment in higher courts were generally greater than those in intermediate and lower courts, reflecting the more complex and higher value cases the former handle. However, there is little information related directly to public liability litigation.

Reflecting the costs of legal advice and representation, it is common practice for insurers to set aside a higher reserve for a claim arising from a letter of demand from a solicitor compared with a similar claim notified to an insurer with no legal input (chapter 4). Additionally, preliminary reserves depend substantially on the court in which the statement of claim is lodged and its location. As would be expected, a much higher amount is allocated for a Supreme Court case compared with Magistrates, County or District Court cases. This also reflects the likelihood that the former cases are likely to be more complex and involve more serious

injuries. These considerations have implications for insurers' claims management strategies (chapter 4). Insurers also noted that, when lawyers become involved, they generally have difficulties negotiating directly with claimants.

There is very little comprehensive information about the contribution that legal costs make to the total cost of claims and for the industry as a whole. The available indications from participants are contained in box 5.1.

Box 5.1 **Legal costs**

The Insurance Council of Australia stated that:

> Preliminary evidence suggests that defendants' legal fees are equivalent to approximately 25% of claims awards. If plaintiffs' legal fees are similar, then total legal fees are roughly half the value of claims awards. Since in many cases defendants are unable in practice to pursue recovery of costs awarded in their favour (usually because the plaintiff has no assets), defendants' insurers bear a large proportion of total legal costs. (2002, p. 20)

The Australian Plaintiff Lawyers Association responded that:

> It is too simplistic to make the assumption that defendant and plaintiff costs correspond. In any event, insurers have a large degree of control over when cases are settled and the cost of legal fees reflects their commercial decision on how to conduct the litigation process. (2002b, pp. 18–19)

The Review of the Law of Negligence stated that:

> The costs of the personal injury liability system comprise the 'primary cost' of compensation and the 'secondary costs' of delivering compensation. Most notable of the secondary costs are legal fees and insurers' administrative costs. Secondary costs are relatively very high. Empirical evidence from research projects conducted over the last 30 years suggests that they make up as much as 40 per cent of total costs. (2002a, p. 14)

In relation to insurers' legal costs, the Queensland Public Liability Taskforce reported:

> Anecdotal evidence suggests that on average, legal expenses per claim would be in the order of 15% of total claim costs. However, legal costs are in fact higher when solicitor and own client costs are taken into account. These figures are not available and vary according to individual agreements between the solicitor and client. (2002, p. 6)

Evidence by Royal & SunAlliance to the Senate inquiry indicated that around 40 per cent of the total cost of claims comprised legal and administrative costs (Senate 2002c, p. E356).

Based on a sample of settled claims, the ACCC found that there has been little change over the last six years in plaintiff legal costs as a proportion of total claims costs:

> Over the years 1996 to 2002, plaintiff legal costs were largely in the range of 20 per cent to 30 per cent of the total settlement with an overall average of 23 per cent. On a case-by-case basis legal costs as a proportion of the settlement varied significantly. Costs lower than 20 per cent were common as were costs in excess of 30 per cent. (2002b, p. 60)

As the Senate Economics Reference Committee stated:

> Without data that identifies specific amounts for both damages and legal costs in awards, plus details of the insurance industry's own legal costs in dealing with these claims, it is not possible to say what percentage total legal costs represents of the overall amount of damages awarded. (2002c, p. 66)

An indication of the incidence of legal costs is provided by Trowbridge (2002b). Based on surveys of insurers and samples of claims, it estimated that the legal costs of bodily injury claims (which includes insurer legal and investigation costs as well as plaintiff legal costs) accounted for almost 30 per cent of public liability claims costs for New South Wales and 20 per cent of public liability claims costs for other jurisdictions. Its analysis of claims costing over $20 000, (which represented around 90 per cent of the total cost of bodily injury claims) found that:

- for claims between $20 000 and $100 000, legal costs represented 35 per cent of the total cost;
- for claims between $100 000 and $500 000, legal costs represented 30 per cent of the total cost; and
- for claims over $500 000, legal costs represented about 20 per cent of the total cost (2002b, pp. 83–5).

PricewaterhouseCoopers combined its own data with that of Trowbridge and found that, for payouts of up to $500 000, plaintiff and defendant legal costs together represented between one-quarter and one-half of total costs. This proportion is considerably less for larger claims (table 5.1).

Table 5.1 **Legal costs as a proportion of settlement costs**

Upper band	*Average size of claims*	*Plaintiff legal costs*	*Defendant legal costs*[a]	*Total legal costs*[a]
$'000	$'000	%	%	%
50	15	10	38	48
100	70	13	25	38
200	135	15	18	33
500	330	10	15	25
750	600	8	12	20
1 000	850	7	10	17
1 500	1 250	6	9	15
2 000	1 750	5	8	13
3 000	2 500	5	8	13
4 000	3 500	5	8	13
5 000	4 500	4	8	12
7 000	6 000	4	8	12

[a] Defendant legal costs include investigation costs.

Source: PricewaterhouseCoopers (2002, table 6.5-1, p. 19).

Even if it were possible to accurately determine the level of legal costs, it is impossible to say what the optimal level should be. While legal costs represent a substantial, if unknown, component of claims management costs, they are a necessary part of a well-functioning public liability system based on the need to determine liability and damages under the common law tort of negligence. It all comes down to the individual judgments of both parties to each claim about liability, when to settle and for how much, and when to continue negotiating.

The introduction of efficiencies which lower legal (or any other) costs or speed up processes could, of course, provide benefits. However, unduly limiting spending on legal costs could preclude lawsuits where the underlying grievances are legitimate and where plaintiffs place a high value on any payment obtained, or limit the capacity of lawyers to act on behalf of insurers to defend unfounded claims.

FINDING 5.1

Legal costs are a necessary part of a well-functioning public liability system based on the need to prove or deny liability and determine damages under the common law tort of negligence. While efficiencies that lead to lower legal, and hence lower claims management costs, are desirable, unduly limiting spending on legal services is not necessarily appropriate and may lead to unsatisfactory outcomes.

5.2 Litigation and court judgments

Incidence of litigation

Insurers advised that the involvement of lawyers in claims has increased. They reported that, typically, around 80 per cent of claims they now receive arrive with a solicitor's letter, compared with perhaps about half that level a decade or so ago. Analysis of a small number of claims by Trowbridge (2002b, p. 88) showed that most claims over $5000 had legal representation and around half the claims under $5000 had legal representation.

Insurers contended that the removal of restrictions on advertising and the rise of 'no win, no fee' services has increased the number of claims. In addition, there has been a general change in the attitude of society towards litigation in recent years. The Insurance Council of Australia said that:

> The population is well educated and the media and other sources have helped people to become more aware of their rights to recover damages from third parties. Record awards receive wide media coverage and there is an increased expectation that "if something happens, someone pays". (ICA 2002, p. 8)

'Litigation' may mean anything from an initial registration of a claim with a court, with no real expectation that the matter will need to be settled by the court, to major court battles which are only finally decided by a judge (and perhaps an appeal court). It is commonly considered to commence when court processes are set in train, that is, when a writ or statement of claim is lodged with a court and served on the defendant. This is also in accord with APLA, which defines litigation, in terms of statistics, as when a court action starts (Thomson CPD 2002, p. 81).

APLA argued that claims of increased litigation are questionable in view of the lack of credible quantitative or qualitative evidence. It cited data collated for the Steering Committee for the Review of Commonwealth/State Service Provision which show an average annual decrease of 4 per cent in the total number of all lodgments (criminal and civil) received by all courts throughout Australia over the period 1997-98 to 1999-00 (SCRCSSP 2001, p. 409). However, more recent data show that the total number of lodgments rose by 9.4 per cent from 1999-00 to 2000-01[1] (SCRCSSP 2002, p. 465). Comparable data for civil lodgments show an average annual decrease of 3 per cent over the period 1997-98 to 1999-00, followed by an increase of nearly 2 per cent for the 12 months to 2000-01 (SCRCSSP 2002, table 9A.1).

Trowbridge (2002a, p. 14) found that the statistics on public liability litigation maintained by the various courts were of limited use. Court statistical systems are not set up to distinguish public liability from other personal injury cases and there is little consistency between one jurisdiction and another. The District Court of New South Wales was, however, able to provide Trowbridge with statistics on the number of new public liability writs lodged in the Sydney region. These showed a steady increase in new personal injury litigated matters for public liability in Sydney, with a doubling between 1996 and 2001, representing an average annual increase of about 15 per cent.[2]

Further work by Trowbridge showed that most courts experienced an increase in the number of civil writs lodged over this period. While recognising the limitations of the data and the difficulties of categorising claims, they concluded that the statistics 'appear to support a view that there has been a steady increase in public liability insurance bodily injury claims over the last five to ten years' (2002b, p. 59). However, APLA has argued that some of the most significant changes in litigation

[1] The data excluded Western Australian lodgments for both years.

[2] Trowbridge indicated that the results should be 'regarded as indicative and not authoritative' as the data were not checked or verified by the Court (2002a, p. 15). In addition, it was not possible to quantify the impact of an increase in jurisdiction of the District Court in 1997 where its limit was lifted from $250 000 to $750 000, with a resulting referral of outstanding matters from the Supreme Court.

rates are due to changes in the jurisdiction limits (monetary limits) of courts, resulting in a transfer of work from one court to another and from legislative changes that have created artificial volatility (Davis 2002, p. 4).

In recognition of the statistical deficiencies, the Ministerial Meeting on Public Liability of 30 May 2002 agreed on the need for a nationally consistent methodology for court statistics. It asked the Standing Committee of Attorneys-General to treat this as a high priority. The Senate committee expressed its support recommending that:

> … the Attorneys-General … work together to ensure that good court data management systems are put in place throughout the country. (Senate 2002d, p. xvii)

In discussions with the Commission, insurers observed that, compared with the past, a higher proportion of claims notifications were now accompanied by a writ (or statement of claim lodged with a court). Insurers indicated that about 40 per cent of claims are subject to 'litigation' in this sense, although the proportion proceeding to trial has remained virtually unchanged over that time, with around 2 to 5 per cent requiring a judgment. As an indication, one large insurer advised that 70 to 80 per cent of claims it receives have plaintiff lawyers involved, 45 per cent are litigated, 5 per cent get to hearings and 2 per cent proceed to a verdict stage.[3]

Litigation is more frequent for larger claims. Trowbridge found that most claims over $20 000 are litigated, half the claims between $5000 and $20 000 are litigated and only a small proportion of claims under $5000 are litigated (2002b, p. 89).

Litigation processes have several consequences. Involvement of a court usually means the insurer will use external legal advisers, rather than handle the claim by internal claims staff. In addition, court costs and barristers costs become an important part of the negotiating equation and this increases in importance as the case takes longer to resolve. If the proceedings are settled on the 'steps of the court' prior to the trial, cancellation fees for Senior Counsel and others normally apply. These could be significant.

FINDING 5.2

The involvement of lawyers in public liability claims has increased, with many insurers reporting that about 80 per cent of the claims they received are now being lodged by lawyers, compared with about half that level a decade ago.

[3] While this is not necessarily the same for all insurers, the general picture that emerges is broadly similar.

FINDING 5.3

Litigation, in the sense of the commencement of court-related processes, has also been increasing, although most cases are settled prior to trial. The proportion of cases resulting in a judgment remains at about 2 to 5 per cent of cases.

Judgments

There is some variation in processes and costs between states. Some participants said that the level of common-law awards and settlements also varies between states and territories. The Institute of Actuaries said that, for a variety of procedural and social reasons:

> There are also observable differences between individual courts and judges. Naturally, plaintiff lawyers attempt to get their cases heard in the most favourable jurisdiction and under the most favourable legislation. This is an equity, as well as a cost issue. These differences also affect the stability of costs. Higher awards in one jurisdiction, or even by a particular judge, can be used as an argument for ratcheting up awards generally. (2002, pp. 9–10)

The Ipp report was also somewhat critical of the variation in court judgments:

> In addition to differences in statutory provisions, there are differences resulting from courts, in the various jurisdictions, not adopting a uniform approach to the assessment of damages. These judicial divergences of approach can produce significant variations in the amounts of damages awarded in similar cases, sometimes involving hundreds of thousands of dollars. (2002b, p. 184)

The Queensland Public Liability Insurance Taskforce noted that Queensland courts had been more conservative than the southern jurisdictions in awarding damages for personal injuries (2002, p. vii).

Some industry participants raised the question of the possibility of 'forum shopping'. This is said to occur when a claimant chooses the jurisdiction in which they issue a legal action, or the liability regime, so as to maximise the potential payout. In relation to jurisdiction, the Law Council of Australia noted that:

> Although insurers have raised this as a matter of concern, it is not possible in Australia to jurisdiction "shop" for the State or Territory laws that best suit your case … Courts must apply the law where the alleged incident occurred, not where the action takes place. (2002a, pp. 51–2)

However, it also noted that, in view of the general move towards the greater use of contract labour in the workforce, individual contractors who would have previously claimed on workers' compensation as employees may now be able to claim on the liability insurance of the principal contractor (2002b, p. 11). There may also be

some discretion in choice of jurisdiction where claims are being made against third parties.

The Trade Practices Act prohibits misleading or deceptive conduct by organisations in trade or commerce, and action may be taken under this Act in some situations which result in personal injury or death. To date, these provisions have been rarely used. However, in view of its proposed changes to cap payments, the Ipp report recommended the removal of the ACCC's power to bring representative actions for damages for personal injury and death resulting from contraventions (2002b, p. 6). The Commonwealth has confirmed that it will amend the Trade Practices Act to support reforms that are nationally consistent and has agreed, in principle, to amend in areas of inconsistency (Coonan 2002b).

5.3 Court-based case management

Over recent years, courts across Australia have developed various mechanisms to streamline court procedures and assist in the timely and efficient disposal of proceedings for civil cases without the need to go to a formal hearing in front of a judge. Virtually all jurisdictions now have some form of compulsory case management which may include pre-trial, status and settlement conferences and alternative dispute resolution (ADR) procedures. There are several types of ADR, the most common involving a combination of mediation and arbitration (box 5.2).

Box 5.2 **Mediation and arbitration**

Mediation is a structured negotiation process whereby an independent and impartial third party (the mediator) is appointed, who is acceptable to the parties. The mediator seeks to assist the parties reach an agreement on a resolution of their dispute. The mediator does not have authority to impose a settlement on the parties but, where requested, may suggest options for settlement.

Arbitration is a formal process where an impartial arbitrator judges the merits of a case and makes a formal recommendation regarding liability and the damages to be paid. Arbitration is often used where either of the parties do not agree to mediation and the ADR has been ordered by the court. In such instances, it is non-binding in all jurisdictions. That is, if either party disagrees with the arbitrator's determination they can have their case heard in court. However, there are severe cost penalties if the aggrieved party does not subsequently receive a significant improvement in damages after trial.

A significant proportion of claims are settled in a court-supervised pre-hearing environment. Court-determined rules may provide important incentives to settle

prior to a hearing. Further, if parties fail to follow the directions of the court or do not adhere to the timetable, the court will impose strict cost penalties on the offending parties and/or strike out claims, cross-claims or defences.

Anecdotal evidence suggested that early pre-trial conference procedures in some states have been very effective. Similar processes in some other jurisdictions, when employed later in the proceedings after considerable expenditure on legal fees has already been incurred, are regarded as less effective. The Queensland Public Liability Taskforce commented that there is still room for improvement:

> Procedural reforms are aimed at reducing the legal costs component of claims settlement … This could involve the introduction of pre-litigation and post-commencement of litigation processes to resolve issues such as liability and the extent of injuries at an early stage especially by the use of alternative dispute resolution processes. This has already been achieved to a large extent by Queensland's *Uniform Civil Procedures Rules 1999* but the Taskforce considers there is further room for improvement. (2002, pp. 33–4)

Recent changes in Queensland introduced in the *Personal Injuries Proceedings Act 2002* require parties to a claim to take steps to resolve the matter before court proceedings can be commenced. These steps include requiring claimants to give notice of a claim before court proceedings can be commenced, requiring a respondent to take active steps to try to resolve a claim, full exchange of material and compulsory conferencing (Senate 2002d, p. 44).

The Senate Committee referred to the success of the '90 day rule' in South Australia, particularly in resolving matters of professional negligence. It said:

> This rule essentially provides that, at least 90 days before commencing an action, a plaintiff must give the defendant notice of the proposed claim. The notice must give sufficient detail of the claim to give the defendant a reasonable opportunity to settle the claim before it is commenced. (Senate 2002d, p. 67)

The Senate Committee considered that 'all states and territories should investigate whether similar procedures could be adopted in respect of [personal injury] claims' (2002d, p. 67). In addition, the Ipp Report included a recommendation to consider the 'introduction of a rule requiring the giving of notice of claims before proceedings are commenced' (2002b, pp. 3, 57).

The National Alternative Dispute Resolution Advisory Council (NADRAC) was established in 1995 to provide independent advice to the Commonwealth Attorney-General on policy issues relating to ADR. NADRAC has referred to the problem of a lack of rigorous evaluation of ADR programs.

In reviewing Western Australia's criminal and civil justice system, the Law Reform Commission of Western Australia commented on the use and effectiveness of

ADRs within that state. It considered that the use of ADRs have the potential to be a cost-effective and prompt means of resolving disputes, but it also noted some limitations (box 5.3).

Box 5.3 **ADR in Western Australia**

ADR has been used increasingly during the past decade and already plays a significant role in the justice system in Western Australia. All courts presently consider a form of ADR for parties involved in civil dispute before a matter proceeds to trial. An officer of the court usually acts as a neutral third party in the ADR process. There is also a range of community options for mediating disputes ranging from 'user-pay' schemes to publicly funded community mediation services.

Mediation is used to reduce the number of matters on the civil list awaiting trial and the court and case management registrar have discretionary power to order parties into mediation. Experience has shown, for example, that:

- Of the approximately 1300 proceedings that were filed in the Supreme Court of Western Australia in 1997, the Supreme Court conducted 283 mediations, of which 25 actions proceeded to trial after mediation failed and 184 matters were resolved prior to trial.
- All parties involved in civil litigation in the District Court must attend a pre-trial conference after the filing of a request for entry to trial. Of the total 7000 actions initiated each year, parties resolve half of all actions filed without assistance from the court, while another 30 per cent are resolved with the assistance of a registrar trained in ADR.

The Law Reform Commission considered that 'the potential for non-adversarial, cost-effective, efficient and prompt resolution of disputes through ADR undoubtedly is attractive' (p. 84). Litigants often prefer settlements achieved through ADR because it is faster and less expensive than waiting for a decision from a judge. However, it also noted that ADR is not necessarily effective and, in some circumstances, can be of doubtful value, particularly where it is part of a standard pre-trial process. If ADR is merely regarded as a step in the process of litigation rather than an important opportunity to resolve the matter, it may become part of a more protracted and expensive litigation process. It considered that the profile of ADR must be raised so that it carries significant weight within the justice system.

Source: Law Reform Commission of Western Australia (1999).

In commenting on the operation of court-connected ADRs, a more recent study by Astor and Chinkin expressed similar sentiments. They said:

> ADR may effect significant cost savings in those cases where it produces a settlement. … Reducing costs to courts by case management and ADR may have the effect of increasing costs to parties. … the effects of early case management and ADR do appear to have beneficial effects in allowing courts to settle efficiently those cases that are

> going to settle, allowing resources to be focused on those cases that need to go to trial. (2002, p. 262)

The Commission is not in a position to comment on the extent to which such initiatives and ADR processes have produced better outcomes in public liability cases. However, arrangements that provide for the early identification of issues and provide the maximum opportunity for resolution before court proceedings are commenced can be important steps to assisting in the early resolution of claims. In many circumstances, early resolution means that the cost of resolving claims will be less and, in the case of bodily injury, rehabilitation may commence earlier. As the Insurance Council of Australia noted:

> Alternative dispute resolution is a technique which, in association with early notification, could lead to faster, cheaper and more effective resolution of claims. (2002, p. 22).

The effectiveness of ADR processes will depend on how they are conducted, the culture of the participants and the philosophy of insurance companies.

FINDING 5.4

All jurisdictions have some form of court-based caseload management and alternative dispute resolution processes. There are cost incentives in place to encourage adherence to these new processes. While similar in broad intent and structure, there are differences in operation between jurisdictions. It is not clear the extent to which these have produced better outcomes in public liability cases.

5.4 Recent or proposed changes in public liability regimes

While the common law provides a broadly similar basis for the treatment of public liability cases across the states and territories, there are also some overriding state and territory statutes that produce differences, such as statutes of limitations and caps on certain payouts (table 5.2). These have become more evident in the recent legislative changes made by New South Wales and Queensland, which have introduced caps on the maximum payout for claims and caps on the economic loss arising from injury. There are similar proposals for change in some other jurisdictions.

Another change relates to the level of legal costs that may be paid by a defendant. Under legislation in Queensland (*Personal Injuries Proceedings Act 2002)*, an order that a defendant pay the plaintiff's legal costs may not be made where the damages awarded are less than $30 000. Where damages awarded are between $30 000 and

$50 000, the plaintiff may recover from the defendant no more than $2500 in legal costs. The Victorian Government has announced that it will pass legislation to like effect. The *Civil Liability Act 2002* (New South Wales) limits legal costs according to a more complex formula. It applies to awards of damages up to $100 000. The ACT with its *Civil Law (Wrongs) Act 2002* adopted a variation of this model (Ipp 2002b, p. 185).

Table 5.2 **State and territory differences in negligence laws[a]**

State	*Caps and thresholds on general damages*	*Caps on economic loss*	*Limits on recoverable legal costs*
NSW	Payouts capped at $350 000. Threshold of 15% of most extreme case.	Cap on past and future loss at 3 times average weekly earnings.	Cap recoverable costs to a maximum of $10 000 or 20% of damages received where the award for damages does not exceed $100 000.
Vic	Proposed reforms to cap payouts at $360 000. No threshold.	Proposed to cap payout to 3 times average weekly earnings.	Proposed that no recovery of legal costs for claims less than $30 000 and cap at maximum of $2500 for claims between $30 000–$50 000.
Qld	No cap or threshold.	Cap payout to 3 times average weekly earnings.	No recovery for claims less than $30 000 and cap at maximum of $2500 for claims between $30 000–$50 000.
WA	No Cap. Threshold of $12 000 indexed to a statutory formula.	Proposed to cap payout to 3 times average weekly earnings.	No reforms made or proposed.
SA	Cap payouts at $241 000. Threshold of 7 day period of impairment or $2750 in medical costs.	Cap of $2.2 million.	No reforms made or proposed.
Tas	No cap or threshold.	No decision made to change current arrangement of no cap.	No reforms made or proposed.
ACT	No cap or threshold.	Proposed to cap payout to 3 times average weekly male earnings.	Limit to $10 000 or 20%, whichever is greater, for claims under $50 000 (effective 1 January 2003).
NT	Proposed cap of $250 000. Threshold for non-economic loss of $15 000.	Proposed to cap payout to 3 times average weekly earnings.	Proposed to limit legal fees in ‘no win, no fee’ cases.

a Current as at 15 November 2002.

Sources: Coonan (2002b); Ipp (2002b table 1, p. 189, table 3, p. 196); ACT *Civil Law (Wrongs) Act 2002*.

The final report of the Review of the Law of Negligence (Ipp Committee) made a number of recommendations relevant to these issues. For example, it expressed the

need for national consistency and recommended that personal injury damages payouts be capped at $250 000 and thresholds (15 per cent of a most extreme case) be introduced to remove small claims. It recommended a cap for loss of earnings of twice the average full-time adult ordinary earnings (equating to about $90 000). It also recommended that legal costs be abolished when less than $30 000 is awarded in damages, and be limited to $2500 where damages are between $30 000 and $50 000 (as in the Queensland legislation). It considered there should be compulsory mediation for some large claims (over $2 million) with a view to securing structured settlements (box 5.4).

Box 5.4 **Structured settlements**

An increased use of structured settlements may improve the settlement process for some large personal injury claims. Structured settlements are an:

> … agreement between a plaintiff and a defendant pursuant to which the defendant is required to pay at least part of the agreed damages periodically rather than in a single lump sum … a structured settlement is based on the lump sum to which the plaintiff is entitled according to the ordinary rules for assessment of damages. Some or all of that lump sum is used to buy an annuity which generates income out of which payments are made to the plaintiff from time to time according to an agreed schedule. (Ipp 2002b, p. 215)

Structured settlements may be suitable for some very large personal injury claims, where the claimant is likely to require ongoing care. They offer tax advantages over lump sum payments, and the regular payments provide increased certainty and security. For the insurer, structured settlements provide a new tool that assists in settlement negotiations and allows them to add value to the settlement package without necessarily incurring greater expenditure. In fact, indications from American insurers are that structured settlements can reduce costs to insurers by about 10 per cent.

Legislation introducing tax exemptions for structured settlements for personal injury claims has passed through Parliament (Coonan 2002c). This initiative was welcomed by the Ipp report, which said that 'more could and should be done to encourage the use of structured settlements in serious personal injury cases' (Ipp 2002b, p. 216).

If such changes were enacted by all states and territories, they could have a significant impact on the costs of claims, and the administrative and legal costs of insurers. However, the extent to which they would lead to uniformity, given the recent changes and proposed amendments to tort law by individual jurisdictions, remains to be seen. Should there be substantial differences across Australia, they may well have the opposite effect and increase some costs to insurers. However, the Commission notes that, at the Joint Ministerial meeting in November, State and Territory Ministers agreed that the key Ipp recommendations that go to establishing liability should be implemented on a nationally consistent basis and each jurisdiction agreed to introduce legislation as a matter of priority (Coonan 2002b).

FINDING 5.5

There is some variation between jurisdictions in claims management costs due to differences in statute law, legal representation costs, and court procedures and costs. If current state and territory reviews of arrangements for public liability insurance lead to greater differences, claims management costs to some insurers could rise further.

APPENDIX

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